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# Healing Power:

The Global Fund,  
Disrupted Multilateralism  
and Mediated Country  
Ownership

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## **Declaration**

This thesis is my own work. It has not been submitted for a degree at another University.



## Summary

This thesis examines the changes in health governance at both global and country levels brought by the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), a self-described public/private partnership intended as a financing mechanism to achieve Millennium Development Goal (MDG) 6. Since the G8 announced the Global Fund's creation in 2001, it has succeeded in mobilising over US\$30 bn in commitments, primarily from donor governments.

This thesis is rooted in the 'high politics' of International Relations (IR), and in particular its literature on globalisation, governance and international institutions. Where this literature has failures or gaps, it draws from the Development Studies and International Political Economy (IPE) literatures. It also relies on key informant interviews undertaken in Geneva, Lilongwe and Zomba with executives of international institutions, and those involved in Malawi's HIV/AIDS response including government representatives and staff from the National AIDS Commission, donors, NGOs and those working on the front line. This thesis relies on a descriptive, single case study to create a 'thick' narrative. Rather than deriving generalisations, it provides a basis for further research into the nature and effects of systemic change in how health is governed that the Global Fund signals.

This thesis makes three contributions to knowledge: 1) It provides a basis to evolve the IR literature on globalisation, governance and international institutions to consider the nature, significance and effects of the Global Fund as a form of institutional innovation which is disrupting the traditional multilateral order, particularly for international institutions working in health; 2) It challenges the use of the term 'country ownership' to mean 'putting the country in the driver's seat', and instead notes the double deficit in external accountability that arises when global politics and country evidence collide in a Global Fund convened elite, mediated space for country ownership; and 3) It synthesises observations from field work in Malawi on the exercise of the Global Fund's authority and its dislocation from external accountability when failures occur. The IR literature is silent on the rise of the Global Fund's authority. It fails to contend with the notion that country ownership is as much about the burden of responsibility as it is about agenda setting. This highlights the dislocation between the loci for authority and accountability despite the Global Fund's growing authoritative territorial claims.

## Abbreviations

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Treatment
ARV	Anti-retroviral (drugs)
AZT	Zidovudine, an ARV
bn	Billions (of dollars)
CCM	Country Coordinating Mechanism
CDC	Center for Disease Control
CHAM	Christian Health Association of Malawi
CIDA	Canadian International Development Agency
CSO	Civil society Organisation
DAC	Development Cooperation Directorate-Development Assistance Committee
DAH	Development Assistance for Health
DALY	Disability Adjusted Life-Years
DfID	Department for International Development (United Kingdom)
ECOSOC	United Nations Economic and Social Council
EHP	Essential Health Package
EU	European Union
FBO	Faith Based Organisation
FCTC	Framework Convention on Tobacco Control
G8	The Group of Eight (France, Germany, Italy, Japan, the United Kingdom, the United States, Canada and Russia)
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GHI	Global Health Initiative
GPA	Global Program on AIDS
GPPP	Global Public-Private Partnership
GTZ	German Agency for Development and Cooperation
H8	The Health Eight (WHO, the World Bank, the GAVI Alliance, the Global Fund, UNICEF, the UNFPA, and UNAIDS)
HIPC	Highly Indebted Poor Country
HIV	Human Immunodeficiency Virus
IFI	International Financial Institution (e.g. the World Bank and the International Monetary Fund)
IHP+	The International Health Partnership
IHR	International Health Regulations

ILO	International Labour Organization
IMF	International Monetary Fund
JICA	Japan International Cooperation Agency
LDC	Least Developed Country
LFA	Local Fund Agent (the Global Fund)
MAP	Multi-Country HIV/AIDS Program
MDG	Millennium Development Goal
MDRI	Multilateral Debt Relief Initiative
MGDS	Malawi Growth and Development Strategy
MK	Malawian Kwacha
mm	Millions (of dollars)
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MoU	Memorandum of Understanding
MSM	Men Having Sex with Men
NAC	National AIDS Commission
NAF	National HIV/AIDS Framework
NGO	Non-governmental Organisation
NHA	National Health Accounts
NSA	National Strategy Application (the Global Fund)
OAU	Organization of African Unity
ODA	Official Development Assistance
OPC	Office of the President and Cabinet (Malawi)
OECD	Organization for Economic Co-operation and Development
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living With HIV and AIDS
PR	Principal Recipient (the Global Fund)
PRSP	Poverty Reduction Strategy Paper
RBM	The Roll Back Malaria Partnership
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infection
Stop TB	The Stop Tuberculosis Partnership
SWAp	Sector-wide Approach (Health)
TA	Technical Assistance
TB	Tuberculosis
TDR	Tropical Disease Research
TERG	Technical Evaluation Reference Group
The Gates	The Bill and Melinda Gates Foundation

Foundation	
The Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
TRIPS	Trade-related Aspects of Intellectual Property Rights
TRP	Technical Review Panel (the Global Fund)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNITAID	International Drugs Purchase Facility
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WFP	World Food Program
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

## **Chapter 1 - Introduction and Framework for the Inquiry**

### **1. Introduction**

[t]he AIDS virus swept across the world, silently, before we even knew it existed.

The worldwide epidemic was well under way by 1981, when AIDS was first recognized and was given a name. Since then, six years have passed and it has taken these six years of discovery and struggle to learn enough to rise above the flood of ignorance and fear and view clearly the dimensions of this new threat to global health...Yet today, remarkably, only six years after the disease was first recognized, we do know enough to seize the initiative to stop AIDS (Mann 1987, 'Statement at an Informal Briefing on AIDS to the 42nd Session of the United Nations General Assembly').

In 1987 Jonathan Mann, the first Director of the World Health Organization's (WHO) Global Program on AIDS declared that enough was known about HIV/AIDS to bring a halt to the pandemic. Yet it was to take until 2001 for the international community to mobilise a coordinated response to HIV/AIDS, what Peter Piot (UNAIDS 2011, p. 23), Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) from 1995 to 2008, described as an "inflection point." This change at the millennium signalled not only the political intent by donor nations to address what had become a pandemic but also the acknowledgement that the scale of resources and the institutional response that would be necessary were unprecedented.

Since 1981 when the United States Center for Disease Control (CDC) first recognised an unusual pneumonia killing homosexual men in the United States, UNAIDS estimates that more than 60 million people have been infected with HIV and nearly 30 million people

have died of HIV/AIDS related causes. Out of 33.2 million people living with HIV/AIDS in 2011, 22.5 million were in Sub-Saharan Africa (UNAIDS 2010d, p. 23). The numbers are staggering as is the acknowledgment that it took almost 20 years for the international community to mobilise a response (UNAIDS 2011, p. 15).

...a defining feature of the first two decades of HIV was the common failure of leaders to put scientific knowledge to use...governmental inaction allowed the epidemic to become a global crisis, with especially harsh consequences in southern Africa (UNAIDS 2011, pp. 17 and 19).

While, as Jonathan Mann noted, enough might have been known in 1987 to halt the epidemic, whether or not and how to do it were other matters.

The creation of what would become The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) was announced in a G8 communiqué (2001, ‘Communiqué, Genoa July 28’) a month after the June 2001 United Nations (UN) General Assembly Special Session (UNGASS) on HIV/AIDS committed to working with the private sector, Non-governmental Organisations (NGOs) and communities on a coordinated response to the HIV/AIDS pandemic (UNAIDS 2011, p. 23). The Global Fund was a new type of institution, describing itself as a “...unique global public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria. This partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing” (2010a, ‘About the Global Fund’). The international community had on its hands a pandemic of extraordinary proportions. Its response signalled not only “a new approach to international health financing”, but also a departure from traditional multilateralism and the once unassailable authority of nation states (Bartsch 2007b, p. 5).

## **2. Framing the Inquiry**

The remainder of this chapter sets out the underlying structure for this thesis. The first section frames the thesis, presenting the puzzle that serves as the foundation for the inquiry. It goes on to provide the rationale for locating the thesis in International Relations (IR) and situating it in particular in the IR literature on globalisation, governance and international institutions. This section concludes by outlining the approach adopted for the inquiry including the two research questions that structured it.

The second section outlines the descriptive, single case method. It argues for why this method was chosen at this juncture in the Global Fund's evolution and relative to the research questions at hand. It describes the data and information that were collected including the conduct of key informant interviews in Geneva, Lilongwe and Zomba all of which ultimately contributed to the 'thick' narrative for the descriptive, single case.

The last section reviews the literature that informs the thesis. It describes where the IR literature on globalisation, governance and international institutions has gaps or fails to explore the dimensions necessary to respond adequately to the puzzle posed. It also provides some definition for terms which are applied in this thesis which compensate for failures in the literature to describe the changes in global and country level health governance. It concludes by outlining the contribution to knowledge that this thesis makes.

### **The Puzzle**

The puzzle at the centre of this thesis seeks to understand how the Global Fund has so rapidly won legitimate authority at global and country levels even though the nature of its innovative design challenges liberal notions of legitimate state authority in the

international system. It investigates how the Global Fund has changed global health governance by looking at the nature of the Global Fund as a form of institutional innovation with distinct sources of legitimacy from traditional multilaterals like the WHO. It examines how the Global Fund's governance affects what is 'country owned'. It finds evidence that its systems of accountability do not keep step with its rapidly growing authority at global and country levels. It asserts that, as revealed by Malawi's failed 2009 National Strategy Application, this disconnect results in a troubling double deficit in external accountability where accountability accrues to donor governments, but not to those whose lives the Global Fund affects. It finds that while the Global Fund may signal an emerging order which pushes the boundaries of traditional state-centric models of legitimate authority, failures reveal that the dissonance between the loci for authority and accountability have yet to be resolved.

### The Location

In order to set a context for this research and analyse how the Global Fund has effected change at global and country levels, this thesis is located in IR from which it draws on the literature on globalisation, governance and international institutions. Where this main literature has gaps or has yet to evolve, the arguments and analysis in this thesis rely on other disciplines. These include the literatures on global and country level public health policy which straddle IR, Development Studies and International Political Economy (IPE)—in the case of the latter particularly with respect to HIV/AIDS—and the policy literatures including those by international institutions and research institutes.

With the emergence of globalisation, the IR discipline is shifting from its traditional point of reference--the realist-positivist focus on the authority of the nation state and state-governed global institutions. However, a new point of reference has yet to take shape.



This means that the IR literature lacks a robust foundation for analysing how the Global Fund both challenges traditional notions of legitimate authority and has captured significant authority at global and country levels in a short period of time. Similarly the IR literature has yet to offer a basis from which to examine the consequences of the Global Fund's new sources of legitimacy, and its weak accountability link. Consequently a more eclectic approach to the literature has been taken in this analysis.

This thesis could have been situated differently in two main ways. First, it could have used a meta-theoretical perspective. This framing was rejected in favour of a literature-based approach primarily because the rise of the Global Fund and its effects at global and country levels is an emergent phenomenon which lacks the stability or maturity that would benefit the structure of an epistemological lens. For example, this thesis concerns the departure of an international institution from a state-centred governance model and the effects of the inclusion of non-state actors and their elite character on aspects of legitimacy, accountability and authority for Malawi's HIV/AIDS prevention strategy and its country-based systems for drug financing and supply. Consequently, the thesis could be framed with a neo-realist focus on the pursuit of hegemonic interests through international institutions. While this framing would serve to analyse aspects of the Global Fund such as its resource mobilisation, it would not provide sufficient breadth to explain its form of institutional innovation holistically. For example, the thesis uses the work of neo-institutionalists, accepting Keohane and Nye's (1977, p. 24) description of complex interdependence where "actors other than states participate directly in world politics." It also both draws on and challenges constructivist views on how non-state actors such as NGOs and Civil Society Organisations (CSOs) have 'socially' shaped the Global Fund and Malawi's country context. Given the Global Fund's emergent nature, a meta-theoretical

framing of the thesis would have precluded or limited the flexibility offered by locating the analysis in the IR literature on globalisation, governance and international institutions.

The second way of situating this thesis would have been to locate it within IPE. IPE suits the analysis of the effects of the HIV/AIDS pandemic because it facilitates linking epidemiology, for example rates of prevalence, incidence and mortality, to economic impact such as slowed economic growth or damaged national factor markets such as labour. As argued by Poku and Whiteside (2004, p. xxii), "...the pandemic is reshaping social, political and economic life in a way that have [sic] not been witnessed previously." IPE is not ignored in this thesis as the chapters which discuss the magnitude of the Global Fund's resource mobilisation and the extent of Malawi's aid dependence indicate but using it as a the point for inquiry may have precluded a more robust analysis on the nature and effects of the Global Fund's governance.

With its focus on institutional innovation within traditional multilateralism and the implications for governance, including aspects of legitimacy, accountability and authority, this thesis locates itself in the IR discipline and draws on its literature of globalisation, governance and international institutions. Necessarily it draws on other disciplines including IPE. The IR discipline and a literature based approach provides a robust and flexible foundation from which to analyse the Global Fund as a form of institutional innovation and an emergent phenomenon with implications for global and country level governance of the HIV/AIDS response.

### The Approach

The inquiry that became this thesis began with curiosity about the Global Fund as a 'different' global institution, one that was succeeding in mobilising significant funds for three diseases, with strong political support from wealthy and powerful states and a self-

proclaimed public/private model. This curiosity was fuelled by the author's professional background which includes academic study of and experience in the design of 'greenfield' organisations and a recognition that institutional innovation of this nature rarely occurs within the multilateral order.

The approach to this thesis was shaped by two research questions:

1. How has the Global Fund changed global health governance and what are the implications for traditional multilateralism, particularly its sources of legitimacy, authority and accountability?
2. How has the Global Fund's governance affected what is 'country owned' with respect to Malawi's HIV/AIDS response and in particular Malawi's HIV/AIDS prevention strategy and what are the implications for accountability to those whose lives are affected?

Following the structure of the two research questions the thesis includes two areas of empirical analysis. The first area focuses on the Global Fund's design and makes a case for its model as a form of institutional innovation distinct from traditional multilateral organisations like the WHO. The second area of empirical analysis describes Malawi's aid reliance, the nature of its health system and its response to its HIV/AIDS epidemic. Both these analyses inform the literature based discussions on aspects of governance which follow them.

In addition to the IR literature on globalisation, governance and international institutions and the complementary IPE literature, this thesis draws key informant interviews with staff of the Global Fund and international institutions in Geneva including the WHO, UNAIDS, UNDP, the Global Alliance for Vaccines and Immunization (GAVI), Roll Back Malaria

and Stop TB and government representatives, staff of NGOs, aid agencies and local consultants to these organisations in Malawi. A list of all those interviewed is included on page 279. Lastly, policy documents including those authored for and by the Government of Malawi, international institutions such as the World Bank and UNAIDS and research institutions such as the Overseas Development Institute (ODI) were an important resource.

The field work conducted in Malawi brought to light the case of Malawi's failed National Strategy Application and the feedback provided by the Global Fund's Technical Review Panel (TRP) on Malawi's HIV/AIDS prevention strategy. This case was selected because it highlights the dissonance between the Global Fund's loci for authority and accountability which its global and country level governance models have failed to resolve. It also highlights the elite nature of country ownership, a departure from claims of inclusiveness meant to imply an association with liberal democratic values of broader participation of non-state actors in decision making and agenda setting. The use of a descriptive, single case in this research is discussed in more detail in the next section on methodology. A detailed discussion on the literatures applied to this research concludes the chapter.

### **3. Devising the Method**

#### The Suitability and Value of a Descriptive, Single Case Study

The context and nature of this inquiry suits a descriptive rather than a cause and effect research design. Yin (2003, p. 23) noted that many investigations have as their main objective description rather than explanation where the 'theory' "covers the scope and depth of the object being described." A descriptive approach for this IR located research was chosen for several reasons:

1. First the Global Fund lacks a comparator. Therefore there is no counterfactual against which to compare the Global Fund's effects or its effects in Malawi. Further, because of the considerable complexity of Malawi's HIV/AIDS epidemic, it is premature to isolate and select variables to compare either with another country or in a 'before' and 'after' scenario within Malawi.
2. Second, the country level research and analysis that has been done is largely in the domain of IPE or the product of population health evaluations because these data are available and accessible and the cause and effect arguments can be made. For example the increase in the number of people on treatment or a decrease in mortality due to HIV/AIDS can be monitored for in-country trends and inter-country comparison. IR as a location for investigation is informed by these data, but not wholly.
3. Third the Global Fund's creation and the international community's efforts to address the HIV/AIDS pandemic is a nascent phenomenon, one that is in the process of maturing rather than one that is subject to summative analysis. In part this is due to the nature of the HIV/AIDS pandemic where "the full effects...on mortality and orphanhood take decades to unfold" (Poku and Whiteside 2004, p. xxi). It is also because endemic countries' ability to respond is recent. Malawi for example began to scale up its HIV/AIDS response only in 2004 when it received its first Global Fund grant.
4. Lastly, because of the unique and formative nature of the Global Fund and its political effects at global and country levels, there is value in developing a more robust understanding of the complex context and variables that explain how change is occurring and how further research might take shape.

A descriptive case study at this juncture in the Global Fund's evolution and Malawi's HIV/AIDS response suits the nature and maturity of these phenomena and can inform reliable and valid future research by uncovering a more refined understanding of the variables at play.

There is debate among scholars as to the validity of a single case study approach used in this research. Most famously, Lijphart (1971, p. 683) favours what he describes as "scientific explanation" provided by the experimental, statistical and comparative research methods which share, "1) the establishment of general empirical relationships among two or more variables, while 2) all other variables are controlled, that is, held constant." Lijphart (1971, p. 691) goes on, somewhat begrudgingly, to acknowledge the value of other research approaches including the descriptive, single case study: "The great advantage...of focusing on a single case [is] that the case can be intensively examined...The scientific status of the case study method is somewhat ambiguous...because...a single case can constitute neither the basis for a valid generalization nor the ground for disproving an established generalization." Lijphart (1971, p. 691) continues his tempered enthusiasm by claiming that "[p]urely descriptive case studies do have great utility as basic data-gathering operations, and can thus contribute indirectly to theory-building." Lijphart's preference for the comparative method is appreciated for its ability to isolate cause and effect and explain change; however, this author argues that it is ill-suited to researching the effects of the Global Fund at this stage in its evolution. This thesis is not an attempt to validate or disprove a generalisation as none exist. Rather, a descriptive, single case study is an essential step in furthering research of a nascent phenomenon which operates in complex global and national contexts.

More recently some scholars have become proponents for the validity of descriptive, single case studies. Campbell (1966, pp. 6-7) for example recanted his early research orthodoxy where “[a]ny appearance of absolute knowledge, or intrinsic knowledge about singular isolated objects, is found to be illusory upon analysis.” Instead he came to promote the value of a descriptive, single case study as imperfect, but as “...all that we have. It is the only route to knowledge--noisy, fallible, and biased though it be. We should be aware of its weaknesses, but must still be willing to trust it if we are to go about the process of comparative (or monocultural) social science at all” (Campbell 1975, p. 179). Flyvbjerg (2006, pp. 223-4) took things farther, claiming that “[s]ocial science has not succeeded in producing general, context-independent theory and, thus, has in the final instance nothing else to offer than concrete, context-dependent knowledge. And the case study is especially well suited to produce this knowledge.” This investigation of the Global Fund and its effects within traditional multilateralism and in Malawi intends to grapple with the “complexities and contradictions of real life... [where]...a particularly “thick” and hard-to-summarize narrative is not a problem...[but] a sign that the study has uncovered a particularly rich problematic” (Flyvbjerg 2006, pp. 223-4). In other words, the descriptive, single case study on Malawi contributes to knowledge on how the departure of an international institution from a state-centred governance model affects aspects of its legitimacy, accountability and authority and has implications at country level as Malawi’s failed National Strategy Application and the TRP’s feedback on its HIV/AIDS prevention strategy shows.

#### Research Design and the Descriptive Case Study ‘Theory’

According to Yin (2003, p. 23), the ‘theory’ of a descriptive case study is derived by defining what the description should include rather than collecting data about ‘everything’.

The inspiration for this research—to know more about the Global Fund including how its governance is institutionally innovative, how it has matured organisationally and its global and country level effects—did not give rise to a comparative theory testing hypothesis but one where the premise is laid by the research questions.

The two research questions for this thesis outlined earlier in this chapter--one that focused on how the Global Fund has changed global health governance and the implications for traditional multilateralism and one that focused on how the Global Fund's governance has affected 'country ownership' particularly with respect to Malawi's HIV/AIDS prevention strategy--set the parameters for the descriptive case 'theory'.

Malawi was selected as the site for the descriptive single case for several reasons. First, the Global Fund is the primary funder of Malawi's HIV/AIDS response. While the United States is a development partner and there is the President's Emergency Plan for AIDS Relief (PEPFAR) funding in the country, the Global Fund dominates by a significant margin. Second, Malawi is a highly HIV/AIDS endemic country so its government and donors are motivated to effect change. Third, Malawi has been politically stable and efforts to address its HIV/AIDS epidemic have not for the period of this study been unduly complicated by conflict, migration, food insecurity and other macro-environmental effects. Lastly, as a practical consideration, English is the language of government in Malawi which facilitated the analysis of documentation.

For each of the two research questions a list of sub-propositions and rival sub-propositions were developed (see p. 263) and these formed the basis for the key informant interview structure and questions (Patton 2002, pp. 344). For example at global level the propositions sought to establish if there were clear leadership roles among international institutions for aspects of the global health agenda, if the Global Fund had changed the



division of labour for health among multilaterals and whether or not the Global Fund had affected the resource mobilisation strategies of other global health institutions. In total 38 interviews were conducted primarily in Geneva and Lilongwe and their transcripts were “organized into readable narrative descriptions with major themes, categories and illustrative case examples extracted through content analysis” (Patton 2002, pp. 5). This approach allowed for exploration of the narrative territory between the sub-proposition and its rival which in turn informed the development of the descriptive case. A pure theory testing approach would have precluded this type of analysis (Flyvbjerg 2006, p. 237). The field research was complemented by analysis of the literatures and documents as described in the literature review section of this chapter. Together, the key informant interviews in the field and the analysis of literature and documents created the ‘thick’, descriptive, single case examining Malawi’s failed National Strategy Application and the TRP’s feedback on its HIV/AIDS prevention strategy.

The descriptive, single case study approach used in this thesis provides rich ground for further research, particularly research that might develop theory related to how the Global Fund has changed global health governance or test theory on the definition and practice of country ownership in specific donor/recipient contexts. Future work might also take a normative path, comparing and developing governance mechanisms and approaches to address the external accountability gap (outlined in Chapter 5). Lastly, there is rich ground for more local research on how the effects of the double deficit in external accountability play out. The descriptive, single case in this thesis is a platform to better formulate hypotheses related to the Global Fund as a form of institutional innovation within the traditional multilateral order and its governance effects at global and country levels.

#### **4. Synthesising Literatures**

This thesis is concerned with the emergence of the Global Fund as a new type of institution in the multilateral context, how its legitimacy, accountability and authority are created and conferred and the implications this has for its multilateral partners at global level and the notion of ‘country ownership’ in the case of Malawi’s HIV/AIDS prevention strategy. The thesis is situated in IR, yet the IR global governance literature fails to adequately deal with four critical factors related to this inquiry:

1. First, the IR literature has yet to evolve to a point where it has refined its terminology and language to adequately describe the departure from a realist-positivist world of the nation state and state-governed global institutions to one where the boundaries blur between state and non-state and national and international spheres. This thesis challenges terms used frequently in the policy domain such as ‘country ownership’ to imply liberal democratic values which do not necessarily bear out in practice. Instead this thesis describes a mediated space for country ownership. The changes in the international order which the Global Fund both exemplifies and furthers lack terminology and language in IR scholarship which are without ambiguity.
2. The Global Fund is a new institutional form but the literature fails to adequately analyse how it differs from traditional multilateral institutions such as the WHO. The early literature on Global Public Private Partnerships in health (for example, Buse and Walt 2000a and 2000b; Buse and Waxman 2001; Caines et al. 2004) addresses the emergence of new organisational models, but fails to explain the Global Fund’s unique design which underpins its sources of legitimacy and strong internal but weak external accountability model. The IR literature on international institutions has so far focused on traditional ‘states as members’ models and does

not contend with the nature, significance or the effects of the Global Fund as a form of institutional innovation within the traditional multilateral order.

3. The current IR literature takes the ‘global’ as its point of reference largely ignoring the country lens as an analytical view into the interplay between the national, the transnational and the supranational. The Global Fund has significant influence on recipient countries, but the IR literature ignores the tensions between the politics of ‘country ownership’, the aid relationship and the elite nature of country-level health policy making. The consequences when global politics and country evidence collide provide rich ground for exploring the ambiguous and unaccountable nature of a ‘national public sphere’ beyond the state. The IR literature has yet to address the governance problems of this Global Fund convened mediated space for country ownership.
4. As the Global Fund matures, its authority at global and country levels has grown. However, its governance model has not kept step. What is emerging is a troubling gap between its authority and its accountability particularly as it plays out when failures occur. The IR literature is silent on the rise of the Global Fund’s authority and how it is exercised. The Development Studies literature informs the analysis of country-level authority, but neither literature contends with the blurring of boundaries between public legitimacy and private power (Slaughter 2004a, p. 169) and the challenge of articulating where these boundaries might lie and who draws them. The literatures do not contend with the ambiguities inherent in the ‘national sphere’ or explore the problem of the Global Fund’s weak authority-accountability link.

The next four sections address how the thesis' arguments were contextualised within the existing literatures, identifying the gaps in the IR literature and the additional sources that were used to create a robust analysis.

### Describing Change

This thesis grapples with several terms that indicate a changing system of institutional governance and political effects. It attempts to describe the gaps between concepts and practices on the ground. This section will describe terms used in this thesis including those that reflect change and which have yet to be assumed by IR scholarship.

First, *traditional multilateralism* refers to a state-centred form of global governance which perpetuates "the dominance of states at the top of the hierarchical state system" (Knight 2001, p. 15). This thesis refers to a 'states as members' model of governance as shorthand for the governance models of traditional multilateral institutions like the WHO. This shorthand is not meant to suggest that this is the only distinctive feature of governance of traditional multilateral institutions.

Ruggie's exploration of the term 'multilateralism'--which he distinguishes from bilateralism and imperialism—results in an often cited definition:

...an institutional form which coordinates relations among three or more states on the basis of "generalized" principles of conduct—that is, principles which specify appropriate conduct for a class of actions, without regard to the particularistic interests of the parties or the strategic exigencies that may exist in any specific occurrence (Ruggie 1992, p. 571).

The concept of coordinated relations, and Ruggie's corollaries that there is indivisibility and an expectation of reciprocity among members applies broadly to the Global Fund's

global and country level governance models; however, the Global Fund deviates in one critical aspect, the unit of analysis. The Global Fund is an international institution which imitates Ruggie's "generalized" principles of conduct' but it includes both state and non-state actors. As one of eight Millennium Development Goals (MDGs)<sup>1</sup> (see p. 268 for a list of the MDGs), MDG 6, to combat HIV/AIDS, malaria and other diseases, serves as the rallying or coordination point for the interests of wealthy and powerful donor countries and recipient countries and also a range of global and country level actors from civil society, private foundations and business. Therefore, traditional multilateralism as referred to in this thesis indicates that it is states which govern.

This thesis' use of the term *emerging order* signals the Global Fund's departure from Ruggie's state-centric construct and its retention of the notion of 'coordinated relations' among those who govern. The recognition that this order is emergent, that it is not fully formed, indicates that the Global Fund's claim of an inclusive alternative to state-centric governance is not without contention, particularly as discussed in this thesis related to legitimacy, accountability and authority.

The second area in this thesis where terminology and language are particularly challenging pertains to the boundaries which define the 'country space' including and beyond the state. This thesis takes liberty with Castell's (2008, p. 80) definition of an 'international public sphere', as a space where citizens, civil society, and the state interact creating a 'global social-political order' where states "cling to the illusion of sovereignty despite the realities wrought by globalization" (Castells 2008, p. 80), adopting the term *national public sphere*. The word 'national' in this case indicates an interest in and focus on change at country rather than global level where, as the field work for this thesis uncovers, there is a dissonance between the loci for accountability and authority. The use of the word 'sphere'

reflects an expansion beyond the state to include non-state national and international actors. This thesis contends the national public sphere is more elite than Castells concedes.

The thesis refers to the ‘country space’—now understood to include and lie beyond the state—as *mediated*. The use of this term alludes to the dissonance between authority and accountability not only relative to the state, but also to national and international non-state actors. That is, authority is not exclusive to the state nor is it intended to be; moreover, accountability is not clearly ascribed except where recipients of Global Fund resources are ultimately accountable to the donor governments which provide them. Without explicit or clear ownership, authority and accountability then are subject to influence and negotiation among a range of state and non-state as well as national and international actors who engage in the ‘country space’, thus lending it a *mediated* character.

Lastly, a significant part of this thesis explores the meaning of *country ownership* (see Chapter 5). It describes the case of Malawi where *country ownership* is advocated by the Global Fund although what the term means is ambiguous. The term carries an association with liberal democratic values but what is meant by ‘country’ and what it is that is ‘owned’ is not made explicit. This thesis challenges the expediency of *country ownership* where it is intended to suggest that the country is “in the driver’s seat” (Stiglitz 1998, pp. 27) when this does not play out on the ground. Consequently, this thesis uses the term *mediated space for country ownership*.

The IR literature and the language of its scholarship faces the challenge of keeping step with the changes that are occurring in the political sphere once dominated by states. This thesis derives, challenges and applies terms in order to more accurately reflect the effects of a changing institutional and governance order.

## Disrupting Multilateralism: Global Health Governance, the Global Fund and Institutional Innovation

The IR literature on global governance of international institutions has largely been honed through analysing the World Bank, the International Monetary Fund (IMF) and where health is concerned, the WHO. The Global Fund is a new type of institution with governance characteristics derived from new sources distinct from those of traditional multilaterals: its inclusive governance model, its *modus operandi* centred on transparency and performance-based funding and the magnitude of funds it has mobilised and distributed for three diseases is without precedent. The IR literature on global governance has yet to come to terms with institutional innovation within the multilateral order and the effects of the Global Fund, particularly as it matures.

The G8 leaders (2001, ‘Communiqué, Genoa July 28’) committed to a new kind of institution when they announced the creation of what would become the Global Fund: “...we have launched with the UN Secretary-General a new Global Fund to fight HIV/AIDS, malaria and tuberculosis... The Fund will be a public-private partnership and we call on other countries, the private sector, foundations, and academic institutions to join with their own contributions - financially, in kind and through shared expertise.” Global public health had risen on the agendas of the world’s political leaders, the subject of ‘high politics’ rather than social policy because of the perceived threats of infectious disease and bioterrorism to economic and political stability and security (Held and Koenig-Archibugi 2004, p. 127; Ingram 2005, p. 381; McInnes and Lee 2006, p. 5; Bartsch 2007b, p. 3; Zacher and Keefe 2008, p. 19; Kickbusch 2009, p. 323). The G8 sought a new mechanism outside of UN and Bretton Woods institutions to address global public health concerns and

in particular MDG 6: to combat HIV/AIDS, tuberculosis and malaria (Buse and Walt 2000a, p. 551; Forman and Segaar 2006, p. 216; Kickbusch 2009, p. 323).

As the 2001 G8 Communiqué lays out, the Global Fund was conceived as a global public private partnership. There is little in the literature that analyses the role of the neo-liberal agenda in shaping the Global Fund's conception, despite the fact that it embraces the private sector, its adoption of an ethos of efficiency and its location outside of the UN. The literature at the time focused on coming to grips with a number of global health initiatives that had emerged due to new sources of funds from donor governments and private foundations such as the Bill and Melinda Gates Foundation (the Gates Foundation) to meet the three MDGs that focused on health. In 2004 the database of global health initiatives maintained by the Initiative on Public-Private Partnerships for Health (IPPPH) listed 92 such organisations.<sup>2</sup> The early literature on the phenomenon of burgeoning health initiatives had two veins: the first sought to define these new institutional arrangements and the second had a more normative bent, proposing how these new organisations should work, particularly how multilateral institutions including the UN should engage the private sector.

Buse and Walt's (2000a, p. 550) early work on public private partnerships for health grappled with assigning a definition to the set of new institutional arrangements that were emerging and proposed that they could be recognised as "...a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour." Several years later Buse and Harmer (2007, p. 259) offered a less prescriptive interpretation of what had come to be described as global health initiatives (GHIs) rather



than global public private partnerships as “relatively institutionalised initiatives, established to address global health problems, in which public and for-profit private sector organisations have a voice in collective decision-making.” Given the diversity of institutional arrangements that these definitions sought to embrace and their range of purpose including advocacy, financing, product development, medical research, and supply chain and procurement optimisation, a one-size-fits-all definition proved to be elusive. It also failed to explain how institutions like the Global Fund were not only different from traditional multilateral institutions, but ultimately could grow in size and authority to become a form of institutional innovation that would change the multilateral order.

The second area of interest in the early literature on GHIs was normative, or how these new institutional arrangements should work (Buse and Walt 2000b; Buse and Waxman 2001; Caines et al. 2004). Some for example derived generalisations from observing a range of GHIs or what they called “aid instruments” (Caines et al 2004, p. 5). Others focused on how traditional multilateral organisations such as the WHO should ‘partner’ with multinational corporations and other private actors:

A useful distinction has been made between partnerships in which the management functions are undertaken by a secretariat within an intergovernmental agency (e.g. the Global Alliance for Vaccines and Immunization) or in a not-for-profit host (e.g. the Mectizan Donation Programme) and those where the management is housed in a separate legal entity (e.g. the International AIDS Vaccine Initiative). A more comprehensive review of WHO’s relations with the private sector should be aware of the spectrum of relationships as well as the diversity embraced by the term ‘partnership’ (Buse and Waxman 2001, p. 749).

The nature of these analyses was a response to the ‘newness’ of these institutional arrangements for global public health. Something was happening in global public health and its governance, but in the early 2000s it was an immature trend and a clear picture had yet to emerge.

In the ensuing decade, the GHI landscape has matured. The Global Fund has become a leader in terms of its institutional size, the magnitude of the resources it has mobilised and distributed and its authority at global and country levels. However, the literature related to its governance, in particular its legitimacy, accountability and authority is weak, treating the Global Fund as an idiosyncratic, narrowly focused organisation rather than a change agent within the multilateral order.

Chapter 3 examines the nature of the Global Fund’s legitimacy (see for example Hurd 1999, p. 381; Suchman 1995, p. 574; Barker 2001 p. 8) and how it is conferred making the case that its innovative institutional design both distinguishes it from traditional multilaterals like the WHO and ultimately contributes to its weak authority-accountability link. The literature on legitimacy is vast (see for example Beetham and Lord 1998, p. 16; Barker 2000, p. 8; Bernstein 2004, p. 12). However a focus on select dimensions such as its rational roots (see for example Green 1988-9, p. 796; Tyler and Darley 2000, p. 724; Slaughter 2004a p. 178; Bernstein 2004-5, p. 154), its normative character (see for example Nanz and Steffek 2004, p. 318; Ruggie 2004, p. 504; Zürn 2004, p. 261; Bartsch 2007b, p. 5), its relational necessity (see for example Beetham and Lord 1998, p. 16; Raz 1981, p. 188) and its self-referential and self-generating capacity (Barker 2000, p. 9) help shed some light on how the Global Fund’s legitimacy is conferred. These features highlight how the Global Fund’s unique institutional design--its inclusive governance at global and country levels, its transparent and performance based *modus operandi* and its

unprecedented resource mobilisation and distribution--both distinguish the Global Fund from traditional multilaterals and provide new sources of legitimacy, making a new argument for how legitimacy is derived beyond the legitimate authority of nation states.

The thesis draws from the well-established literature on the democratic legitimacy of international institutions and global forms of governance (see for example, Nye 2001, p. 3; Nanz and Steffek 2004, p. 315; Keohane 2006, p. 14) which acknowledges the dislocation of legitimacy and legitimate authority from the realist-positivist focus on the nation state and state-governed global institutions (see Ruggie 2004, p. 519; Nanz and Steffek 2004, p. 315; Castells 2008, p. 78). It considers the varying views on the extent of this dislocation (see for example, Beetham and Lord 1998, pp. 17-18; Ruggie 2004, p. 504; Zürn 2004, p. 277). It also acknowledges the substantial discourse on democratic legitimation that arises which includes debate on the existence or extent of a democratic deficit (Moravcsik 2004, pp. 346-7; Börzal and Risse 2002, p. 18) and the role that civil society may be seen to play in addressing it (Nanz and Steffek 2004, p. 323). It argues that Barker's (2000 p. 9) notion that legitimating can be a self-referential and self-generating act is particularly relevant in the case of the Global Fund as it puts in relief the role and even the payoff of claims of inclusiveness and transparency when as Stone (2008, p. 26) describes, "[a]genda setting is more contested, externalized beyond the nation-state, and open to the input and disruption of a variety of political agents."

The discussion in Chapter 3 makes the case for Global Fund's sources of legitimacy as a departure from what appears at first glance to be input-oriented legitimacy or 'government by the people' defined by Scharpf (1999, p. 2) where member states govern. Rather it makes the argument that they are akin to output-oriented legitimacy or the "capacity to solve problems requiring collective solutions" and are subject to what Barker (2000, p. 9)

identifies as the act of legitimising where “the absence of democratic legitimation will throw into relief how much legitimation is by government and for government...where the legitimating activities of government... more contested and more varied.” The Chapter asks the question of legitimacy in whose eyes, asserting that the Global Fund’s legitimacy is ultimately held in the eyes of wealthy and powerful states. Unravelling the nature of the Global Fund’s legitimacy requires piecing together select dimensions on the broad literature on legitimacy, considering how the Global Fund’s design departs from the traditional conception of legitimate authority resting with the nation state, and uncovering its output-oriented nature despite input-oriented claims of inclusiveness and transparency.

The well-established literature on accountability of international institutions relies on their constitutive ‘states as members’ governance and the role of national governments, civil society and NGOs in holding these institutions to account (Woods and Narlikar 2001, p. 574; Held 2004, p. 372; Koenig-Archibugi 2004, p. 237; Grant and Keohane 2005, pp. 31-2). Grant and Keohane define the accountability problem of International Financial Institutions (IFIs) by distinguishing between two models: a participatory model where people with power are accountable to those who are affected by their decisions and a delegation model where people with power are accountable to those who have entrusted them with it. The problem arises according to Grant and Keohane (2005, p. 33) when IFIs practise both:

...the IMF might be considered accountable to those whose money it is lending to take only reasonable risks, which leads to a policy of requiring structural adjustments. But it is also called to account for the effects of those structural adjustments within the countries accepting the conditions of IMF [International Monetary Fund] loans.

This analysis of the structural and procedural issues related to accountability of IFIs--who is accountable to whom and how they are held to account--does not consider new types of institutions in the multilateral order, particularly the Global Fund with its output-oriented legitimacy.

Accountability as it relates to the role of non-state actors in IR is analysed by several scholars. For example, Scholte (2004, p. 212) explores the role of civil society in holding global and national power-wielders to account and reflects on the weak accountability of many CSOs to their own stakeholders. Benner, Reinicke and Witte (2004, p. 198) explore accountability in global public policy networks arguing that electoral and hierarchical accountability models cannot work and new, multidimensional models need to be devised because by their nature networks are “diffuse, complex and weakly institutionalized collaborative systems...[without] an electoral base..[or] clear principal–agent relationships.” Stone (2008, p. 23) in her work on global public policy and transnational policy communities argues that the space between the traditional, hierarchical conception of global/national accountabilities and the ideal of deliberative world government deserves attention where “new forms of authority are emerging through global and regional policy processes that coexist alongside nation-state processes.” Bull (2010, pp. 226-7) takes a different tack, concerned more with the elite nature of the governance of global initiatives like the Global Fund and the consequences for agenda setting. What these scholars infer is that these new forms of authority are less powerful than that of international institutions, particularly the IFIs. That is, they may “coexist alongside nation-state processes” and influence them, but they are not ‘above’ them. From the perspective of the Global Fund, the gap in this literature is in considering the role of non-state actors as embedded in the governance of an institutionally innovative multilateral, one that has grown its authority to

match that of other health international institutions in a short period of time. In other words, if a new order is emerging, traditional authority holders are challenged.

To frame and analyse the Global Fund's accountability problem, this thesis draws on Keohane's (2002, pp. 14-15) distinction between internal accountability--the hierarchical principal/agent relationship between recipient countries, the Global Fund and donor governments--and external accountability--"accountability to people outside the acting entity whose lives are affected by it." The thesis argues that the Global Fund with its output-oriented legitimacy has an accountability gap. In other words, there is a governance problem that arises when institutional innovation departs from the "doctrine of sovereignty" (Keohane 2006, p. 11) particularly at country level where accountability flows upwards to the Global Fund and donor governments, but not outwards for example to Malawians who are affected by HIV/AIDS. In other words, the literature fails to come to terms with the Global Fund's departure from a 'states as members' model of governance, where the answer to the question to whom is the Global Fund accountable remains donor governments. Moreover, this thesis argues that the Global Fund's model creates a double deficit in external accountability: first the Global Fund's external accountability gap is exacerbated by the mediated space for country ownership created by the Global Fund's elite in country governance model; and second, the influence of the Technical Review Panel (TRP)--the group of independent experts which decide on which proposals are funded--its apparent activism and absence of accountability to 'country owners'.

The IR literature on the governance of international institutions reflects their 'states as members' model. It has yet to evolve to reflect the Global Fund as more than an idiosyncratic GHI, as an institutional innovation within the multilateral order that creates

and confers legitimacy in new ways. The IR literature on global governance related to accountability largely bases its analysis on the IFI model, rather than a model like the Global Fund's which includes non-state actors. Where non-state actors, including the elite, and new models of engagement are considered they are assumed to be less powerful. Consequently, the Global Fund's accountability gap--its failure to be accountable to those whose lives it affects—is not recognised in the literature as an institutional failure of an innovative and authoritative new order multilateral.

### The Mediated Space for Country Ownership: the Aid Relationship and Health Policy

The recent IR literature on global governance has concerned itself with the global, transnational or supra-national view. The country-level effects of new global institutions and governance models like that of the Global Fund tend to be analysed with the 'global' as the point of reference, rather than the 'country'. Developing a picture of the 'country space' particularly the implications for country ownership, the aid relationship and health policy when global politics and country evidence collide requires piecing together policy and scholarly literatures and interviews with country-level policy makers and influencers.

'Country ownership' is not a tenet or discourse of global governance in the same way as legitimacy or accountability. Rather it is a term that implies a departure from the failures of the economic reforms and a reframing of the nature of the donor/recipient relationship associated with the Washington Consensus. In order to discuss country ownership as it is promoted by the Global Fund and realised in countries like Malawi, at least two literatures must be consulted. One literature is not academic in nature; rather, it lies in the policy documents, speeches and compacts from international institutions such as the World Bank and the Organization for Economic Co-operation and Development (OECD). For example, in 1998, Stiglitz (1998, pp. 27 and 1) who was then the World Bank's Chief

Economist, described the principle of country ownership as “putting the country in the driver’s seat” after the “failures of the Washington Consensus.” A year after Stiglitz’s remarks the World Bank introduced the Comprehensive Development Framework for which country ownership was one of four core principles, where it meant citizen participation in “shaping development goals and strategies” (World Bank 2003, p. xviii). Country ownership was a phrase which intended to symbolise an end to what had been an era of ‘IFI ownership’ of failed structural adjustment policies.

Country ownership is embedded in the OECD’s Paris Declaration and the more recent Accra Agenda. These compacts between international institutions, donor governments, recipient governments, and in the case of the Accra Agenda members of civil society, were meant to set out guidance on how to make aid more effective. For example, the Accra Agenda identifies strategies for strengthening country ownership such as “broadening the country level policy dialogue on development” where parliaments are responsible for country ownership and all actors including “central and local governments, CSOs, research institutes, media and the private sector are engaged in policy dialogue” (OECD 2008, pp. 16). Here country ownership is intended to promote a deliberative country-level discourse on policy-making but accountability remains with the state. The policy literature of international institutions uses ‘country ownership’ conceptually to signal change in the nature of the relationships between international institutions and country governments and country governments and their non-state constituencies. Whether or how this change is realised is another matter.

The literature on country ownership and the Global Fund is academic rather than policy oriented, but it is in part Global Fund authored. Michel Kazatchkine, the Global Fund’s Executive Director from 2007 to 2012, and Rifat Atun, formerly the Global Fund’s



Director of Strategy, Performance and Evaluation (2009, p. S68) authored ‘Promoting Country Ownership and Stewardship of Health Programs: The Global Fund Experience’ where they posit that the Global Fund’s in-country governance model has had a “catalytic effect”, responding to deficits by “building the capacity of local health leadership to improve governance of HIV programs.” These examples of policy and academic literatures which address country ownership demonstrate that there is no governance literature on country ownership per se. It is a term in the policy domain of international institutions and promoted by them but the larger global governance literature is largely silent on its definition or its effects on policy making and the relationships among international institutions, donor governments, recipient country governments and civil society. This thesis endeavours to challenge the implied meaning of ‘country ownership’ and instead provide a more nuanced understanding of the dynamics of agenda setting, authority and elite participation that play out on the ground in what is a mediated space for country ownership. Moreover, it makes the case that ‘country ownership’ includes a burden of responsibility regardless of where failures occur.

The literature on aid, its impact and governance is extensive and crosses disciplines and sectors. There are a number of ‘sub-sets’ of this larger literature. For example, the IPE literature on HIV/AIDS addresses the social and economic impact of the pandemic (for example Poku and Whiteside 2004, p. xxi) and consequently the role of aid. This thesis makes reference to aid architecture, another ‘sub-set’ of the larger aid literature, which resembles the country ownership literature in the sense that it draws from the research of policy makers particularly those from international institutions. In the case of the former, this thesis cites work by staff of the World Bank, the Center for Global Development and the Overseas Development Institute (for example, Christiansen and Rogerson, 2005, p. 1; Birdsall 2007, p. 593; Bourguignon and Sundberg 2007, p. 319; Booth 2008, p. 2). These

policy oriented sources provide a critique of aid practices and international instruments such as the Accra Agenda with donors as the point of reference—the implications for countries are considered but for the most part are generalised.

The aid architecture literature makes a case for the emergence of a new architecture which is described by the World Bank's Bourguignon and Sundberg (2007, p. 319) as having “two features: one is the country ownership of a development strategy around which donors align and the second is the allocation of aid based on performance.” The literature argues different views on the maturity of this architecture (for example, Lele, Sadik and Simmons no date, p. 1; Bourguignon and Sundberg 2007, p. 319; Birdsall 2007, p. 593; Strand 2007, p. 227; Bonnel 2009, p. 165), nevertheless there is agreement that adoption of the principles of the Paris Declaration and the Accra Agenda by donor and recipient governments and the influence of new entities like the Global Fund point to changes in an aid environment once shaped by the structural adjustment policies of the IFIs. Like the policy literature on country ownership, the point of reference for aid architecture is the ‘global’ or in this instance donors and IFIs-as-architects, rather than the ‘country’ view.

The donor and IFI perspective as central to the promotion of country ownership and as architects of what is ‘new’ in aid is echoed in the health policy literature. The global view dominates (for example Kickbusch 2000, p. 980; Buse, Drager, Fustukian and Lee 2002, p. 253; Fidler 2007, p. 8; Walt, Spicer and Buse 2009, p. 63), and there is little or no current scholarly analysis on how globalisation and the effects of new policy influencers at country level like the Global Fund have affected how country health policy is made and by whom. The exception is a literature with one foot in scholarship and another in evaluation where the country level outcomes of global level initiatives are analysed in a global governance rather than a country health policy context (for example Brugha et al. 2004, p.

100). To fill this country level health policy gap, this thesis refers to a longstanding literature on country health policy (for example, Cassels 1994, p. 336; Walt and Gilson 1994, p. 355; Okuonzi and MacRae 1995, p. 131), Malawi's health policy documents and donor reports (for example, Government of Malawi 2000, p. 2; Government of Malawi Ministry of Health Department of Planning 2004, p. 1; Government of Malawi 2004, p. 6; Carlson et al. 2008a, p. 63; Carlson et al. 2008a, p. 62) and finally interviews with those making and influencing health policy in Malawi. The country level health policy perspective—how policy is made and by whom—is dormant in the current globally focused health policy literature and requires piecing together from scholarly and policy research as well as key informant interviews.

Given that 'country' is interpreted from the perspective of the 'global' in terms of country ownership, aid architecture and health policy it is not surprising that the current global governance literature pays little attention to the 'country space' and how it is mediated. Castells (2008, p. 80) describes an "international public sphere," a space where citizens, civil society, and the state interact creating a "global social-political order" where states "cling to the illusion of sovereignty despite the realities wrought by globalization."

Similarly, other scholars have analysed this 'global space' (for example Benner, Reinicke and Witte 2004, p. 194; Slaughter 2004a, p.160; Stone 2008, p. 20); however, the implications of these supranational interactions at country level and particularly for national governments is not a focus. This gap in the literature is especially problematic as the Global Fund has created, through its country level governance model, a mediated space beyond the state where health policy related to the three diseases is made and influenced by an elite enclave of actors. This thesis argues that the dilution of the state's traditional accountability for health policy and for the well-being of its population coupled with the Global Fund's hierarchical, internal accountability model has created an accountability

gap. This gap is conceptualised by scholars (for example, Keohane 2002, pp. 14-15; Grant and Keohane 2005, p. 34), but the literature analysing how this plays out at country level--particularly as it relates to elite state and non-state and national and international actors--is silent.

The departure in the IR literature from the realist-positivist focus on the primacy of states to a neo-institutionalist focus on the role of international organisations, and further, towards the cosmopolitan ideal of a global government has resulted in losing touch with the 'country space'—what it is and how it is affected by global forces. This thesis argues for a return to country-level analysis which considers the rich ground of how the global affects the country—in the instance of Malawi's HIV/AIDS prevention strategy where global politics and country evidence collide--and in particular the implications for the role and accountability of elite and non-elite state and non-state actors in health policy making.

#### The Intersection of Global and Country: The Weak Authority-Accountability Link

The Global Fund's distinct sources of legitimacy conferred by wealthy and powerful states along with its organisational maturation explain its growing authority at global and country levels. Traditionally, IR locates authority in the domain of states, but this conceptualisation has been challenged by the effects of globalisation and the emergence of legitimate forms of non-state authority (Mason 2004, p. 2; Ruggie 2004, p. 504; Pattberg 2005, p. 591). One example is the literature on authority which posits that "[a]s long as there is consent and social recognition, an actor—even a private actor—can be accorded the rights, the legitimacy, and the responsibilities of an authority" (Biersteker and Hall 2002, p. 204). The idea that the Global Fund's legitimate authority can be derived beyond the state is accepted in the literature; however, the extent to which this legitimacy can be

conferred a 'publicness' and contribute to a growth in authority and new territorial claims is not reflected.

This thesis examines the relationship between the Global Fund's distinct sources of legitimacy and its growing authority at global and country levels. To make a case for the Global Fund's form of non-state authority including the 'publicness' conferred on it and to explain its rapid rise, it is necessary to complement IR scholars' notions of authority associated with bureaucracy and hierarchy (for example Barnett and Finnemore 2004, p.21) and draw on concepts of authority from the Development Studies literature (for example Hyden 2008, p. 12; Kelsall 2011, p. 84; Khan 2005, p. 714) which describe the role of non-democratic authority in the African country context. While the hierarchical concept of authority applied to international institutions explains the Global Fund's growing authority at global level, the country level dynamic is more complex. This thesis argues that beyond the aid relationship, the Global Fund's authority at country level takes a hybrid form through the CCM. On the one hand it overrides socially-based authority through its bureaucratic approach based on formal institutions and impersonal rules, but it also creates a type of social authority through its elite national and transnational character. The IR literature alone fails to tell the story of the Global Fund's distinct sources of legitimacy conferred by wealthy and power states and the nature of the 'publicness' of its authority, its rapid rise and how this serves to both exacerbate and obscure its weak authority-accountability link.

The literature clearly progresses beyond notions of legitimate authority as 'public' and belonging to the state. While scholars acknowledge that diffuse structures have an accountability challenge (van Kersbergen and van Waarden 2004, pp. 157-8; Benner, Reinicke and Witte 2004, p. 194), they have yet to address the Global Fund's weak

authority-accountability link where there is a Slaughter describes, a “blurring of lines of authority [which] are ultimately likely to blur the distinction between public legitimacy and private power” (Slaughter 2004a, p. 169). The question of how those in authority are held to account and by whom when global and county level systems fail remains unanswered. As one interviewee observed, “[t]he big question is whether the Global Fund is set up for this type of burden of responsibility. And I would argue that it is probably not” (International CCM Member 2010, interview, Lilongwe).

## **5. Contribution to Knowledge**

The IR literature on globalisation, governance and international institutions frames the discussion in this thesis. However, given the research questions that were posed, other literatures and sources were required to fill gaps where the IR literature either has yet to evolve or fails to address certain phenomena. As a result of synthesising literatures among distinct disciplines, and conducting key informant interviews to uncover new insights, this thesis makes a contribution to knowledge in three ways:

1. It provides a basis to evolve the IR literature on globalisation, governance and international institutions to consider the nature, significance and effects of the Global Fund as a form of institutional innovation which is disrupting the traditional multilateral order, particularly for those international institutions working in health. IR has largely focused on traditional international institutions as the exhaustive analyses of the governance of IFIs, the WHO and the UN writ large indicate. The Global Fund as a financing mechanism for three diseases would then lie outside this ‘high politics’ tradition. Therefore its treatment in this thesis as a maturing and institutionally innovative international institution which exercises authority among traditional multilaterals is in itself new—in other words making the case that the

Global Fund is now ‘one of the club’ contributes to the IR literature on the governance of international institutions. It describes how the Global Fund creates and confers new sources of legitimacy, how these sources link to accountability, and the troubling double deficit in external accountability that emerges--a deficit which is both exacerbated and obscured by the Global Fund’s growing authority at global and country levels.

2. It challenges the use of the term ‘country ownership’ to mean “putting the country in the driver’s seat”, and instead notes the double deficit in external accountability that arises when global politics and country evidence collide in a Global Fund convened mediated space for country ownership. It describes how the Global Fund affects HIV/AIDS agenda setting in Malawi, and the dynamics of the state and non-state and national and international character inherent in this elite ‘national public sphere’. Its country rather than global, transnational or supranational view coupled with the identification of the Global Fund’s double deficit in external accountability is a new contribution to the analysis of global health governance beyond traditional multilateral institutions.
3. It synthesises observations from field work in Malawi on the exercise of the Global Fund’s authority and its dislocation from external accountability when failures occur. The IR literature is silent on the rise of the Global Fund’s authority, its legitimating ‘publicness’ and how it is exercised. The Development Studies literature informs the analysis of country-level authority, but neither literature contends with the challenge of articulating boundaries for this Global Fund convened mediated space for country ownership and how country ownership is as much about the burden of responsibility as it is about agenda setting. The thesis

argues that the dislocation between the loci for authority and accountability remain unresolved despite the Global Fund's growing authoritative territorial claims.

The puzzle at the centre of this thesis asked how the Global Fund has so rapidly won legitimate authority at global and country levels even though the nature of its innovative design challenges liberal notions of legitimate state authority in the international system. The 'thick narrative' that formed the analysis in response to this puzzle makes a contribution to knowledge by evolving the current IR literature on globalisation, governance and international institutions. It creates new insight into 'country ownership' and the elite nature of the new 'national public sphere' and synthesises its analysis of the Global Fund's growing authority uncovering the weak authority-accountability link that underlies an emergent multilateral order.

## **6. Conclusion**

This is a thesis on organisational innovation and systemic change. It is grounded in IR, and in particular it takes a literature-based approach. Where the main IR literature on globalisation, governance and international institutions has gaps or has yet to evolve, the arguments and analysis in this thesis turn to the literatures on global and country level public health policy which straddle IR, Development Studies and International Political Economy (IPE) and the policy literatures including those by international institutions and research institutes. Although rooted in the IR literature, the analysis in this thesis draws on and synthesises from other disciplines and academic and policy sources as well as key informant interviews to consider the Global Fund as a form of institutional innovation with implications for global and country level health governance.

Because the Global Fund and its effects on global and country level governance are nascent, this study takes an exploratory approach using a descriptive, single case study. It



rejects a cause and effect or comparative approach on several grounds: the Global Fund lacks a comparator which precludes a counterfactual analysis; there is little IR country level analysis and data related to policy, agenda setting and HIV/AIDS on which to rely; and finally, the emergent nature of its subject means that it is too early for summative analysis which would facilitate comparison. A descriptive, single case study method is intended to create a 'thick' narrative and provide a basis for further research.

Although the thesis is located in the IR literature on globalisation, governance and international institutions, investigating the particular puzzle posed required compensating for gaps in and failures of this literature. These gaps or failures take four forms: first, IR scholarship requires new terms or clear definitions for existing terms to adequately reflect the change that is occurring in global health governance. Second, the Global Fund is recognised as a new type of institution, but little analysis exists that explains how it is differentiated from or compares to more traditional multilateral health leaders like the WHO. The Global Fund is not recognised as a form of institutional innovation within the multilateral order. Third, while the IR literature reflects the interplay between the national, the transnational and the supranational, it does so from a global perspective. That is, the country lens is absent and therefore other literatures and new research are required to tell the story of the governance problems of this Global Fund convened mediated space for country ownership. Lastly, the IR literature is silent on the rise of the Global Fund's authority and how it is exercised. While the Development Studies literature informs the analysis of country-level authority, neither literature contends with the challenge of articulating boundaries for this Global Fund convened elite 'national public sphere' beyond the state. Taken together, these gaps or failures require turning to related literatures including the IPE and policy literatures from international organisations and

research institutes. The key informant interviews conducted primarily in Geneva and Lilongwe were also an important puzzle piece.

The contribution to knowledge is made by this thesis in three ways: it evolves the IR literature on globalisation, governance and international institutions to consider the nature, significance and effects of the Global Fund as a form of institutional innovation which is disrupting the traditional multilateral order; it offers new insights related to ‘country ownership’ and the governance problems that arise when global politics and country evidence collide in a Global Fund convened mediated country space; and finally it synthesises the analysis on the Global Fund’s governance, its organisational maturation and its rapidly growing authority to make a case for a problematic authority-accountability link in the governance of a new and emerging multilateral order.

The chapters that follow forward the critical analysis and arguments in this thesis by first setting out in Chapter 2 a description of the Global Fund as a form of institutional innovation which is disrupting the multilateral order. Chapter 3 analyses the nature of the Global Fund’s legitimacy, and makes the link between its output-oriented nature held in the eyes of wealthy and powerful states and its internal accountability model. This is the source of the Global Fund’s external accountability gap. Chapter 4 turns to Malawi, and lays out an empirical analysis of Malawi’s intractable circumstances including its HIV/AIDS epidemic, and the nature of the health system that supports its response. In Chapter 5, the notion of ‘country ownership’ is explored. This chapter presents the case of Malawi’s failed 2009 National Strategy Application to the Global Fund and the nature and influence of the TRP’s feedback on its HIV/AIDS prevention strategy as an example of the collision between global politics and country evidence. It concludes by describing the Global Fund’s ‘double deficit in external accountability’. The final chapter in the thesis

analyses the nature of the Global Fund's growing authority at global and country levels that has accompanied its organisational maturation and how this plays out on the ground in Malawi. It argues that authority as it is exercised by the Global Fund serves to both exacerbate and obscure a troubling weak authority-accountability link suggesting the Global Fund's burden of responsibility is greater than its capacity to govern it.

## **Chapter 2 - The Global Fund: Institutional Innovation and Disrupted Multilateralism**

### **1. Introduction**

...the old formulas of Westphalian governance have failed and a new generation of innovation from many actors is emerging to take its place. But while the new vulnerability provides an increasingly powerful driver, a new world of institutionalised innovativeness and multi-centred sovereignty has yet to replace the Westphalian order of old (Kirton and Cooper 2009, p. 309).

The Global Fund is a form of institutional innovation among global institutions that has disrupted traditional multilateralism. Even though as Kirton and Cooper assert a new multilateralism has yet to emerge, what is evident is that the Global Fund is shaping this new order and in the process irrevocably changing what is left of the old. The Global Fund's design, its institutional innovation is the catalyst. In particular, its inclusive governance, its transparent and performance-based funding modus operandi and its unparalleled resource mobilisation have underpinned the Global Fund's success and contributed to its evolution beyond its initial three disease, vertical focus. Its form of institutional innovation has changed the traditional leadership and division of labour landscape among other international institutions working in HIV/AIDS, tuberculosis and malaria, particularly the WHO, UNAIDS, UNDP, the World Bank and Roll Back Malaria and Stop TB. The nature of the Global Fund's disruption includes its momentum towards policy making at global level, its creation of an 'unfunded mandate' for technical assistance at country level and finally the competition it has created and faces to sustain its resource mobilisation efforts. The Global Fund emerged from a confluence of events at the beginning of the millennium which laid a foundation for change. It has risen to

become a global health leader among traditional multilateral organisations in its scale, size and influence and is an example of institutional innovation changing the multilateral order that Kirton and Cooper describe.

This chapter has four parts. The first section describes the forces at the new millennium that prepared the ground for the Global Fund's emergence. The second section explores the motivations and effects of the inclusion of private actors in what had traditionally been a public domain of multilateral institutions governed by states. The third section makes a case for the Global Fund as a form of institutional innovation, focusing on features of its design and contrasting them with what is perhaps the most traditional health multilateral, the WHO. The final section discusses the nature of the Global Fund as a disruptive force within the multilateral order focusing on policy making at global level, technical assistance and coordination at country level and the challenging nature of resource mobilisation.

## **2. Preparing the Political, Discursive and Financial Ground**

By the beginning of the new millennium, the UN's approach to global public health concerns had undergone transformation. Globalisation and its effects including the relationship between infectious disease, global security and poverty required international cooperation beyond the confines of traditional multilateralism if devastating epidemics like HIV/AIDS were to be addressed (Held and Koenig-Archibugi 2004, p. 127; Ingram 2005, p. 381; McInnes and Lee 2006, p. 5; Bartsch 2007b, p. 3; Zacher and Keefe 2007, p. 16, 2008, p. 19; Kickbusch 2009, p. 323). For the purposes of this work, 'traditional multilateralism' refers to a state-centred form of global governance which perpetuates "the dominance of states at the top of the hierarchical state system" (Knight 2001, p. 15). Given this definition, traditional multilateral organisations are those where states form the governing bodies of international institutions, such as the WHO's World Health Assembly

which is comprised of delegations from 193 member states (World Health Organization 2011c, ‘Sixty-fourth World Health Assembly’). This section describes the forces of transformation at the millennium including the desire of states to cooperate on issues of health, particularly in response to the HIV/AIDS pandemic, the discursive arguments for global public goods and the availability of new resources to address public health on a global scale. Together these factors contributed to the transition of health from a concern of national, social policy to one where global public health became the subject of ‘high politics’, in the interests of wealthy and powerful states.

One outcome of the transformation towards global public health was the creation of a new type of global organisation broadly referred to as a Global Health Initiative (GHI). The Global Fund is one among a number of GHIs that have emerged since the late 1990s. Despite the burgeoning trend, GHIs are not a new phenomenon. For example, Tropical Disease Research (TDR) was established in 1975 by the WHO, the UNDP and the World Bank. Its goal was to strengthen research capacity in disease-endemic countries and support the development of new tools and strategies for neglected tropical diseases (Tropical Disease Research, ‘Making a Difference’). Initially, GHIs were called Global Public Private Partnerships (GPPPs) which Buse and Walt (2000a, p 550) defined as “a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour.” This early definition was an attempt to understand a new institutional phenomenon in global public health.

While some GHIs meet Buse and Walt’s criteria, many do not. GHIs vary in their missions and models and in the range and interests of partners—some advocate, some

fund, some develop products, some conduct research and others address market weaknesses by creating supply chain and purchasing mechanisms. By comparison to TDR the Diflucan Partnership Program is an example of a drug provision and supply chain GHI which is run by Pfizer, the global research-based pharmaceutical company, to provide its drug free to HIV/AIDS endemic developing countries (The Diflucan Partnership Program (2009), 'Welcome'). The Global Fund (2010a, 'About the Global Fund') is also distinct, describing itself as "a unique global public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria. This partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing." New GHIs proliferated as the millennium began but they were institutionally diverse, or by the Global Fund's own definition 'unique', resisting categorisation.

### The Commitment of Global Leaders

On June 27, 2001, then-UN Secretary-General, Kofi Annan held a press conference with Peter Piot, then-Executive Director of UNAIDS (United Nations 2001b, 'Press Release'), to announce the UN Declaration of Commitment on HIV/AIDS: *Global Crisis — Global Action*. The declaration outlined the careful groundwork that had been laid for the UN's special session on HIV/AIDS to get the world's leaders on board (United Nations 2001a, 'Declaration of Commitment on HIV/AIDS'). This included a series of commitments from heads of state in every region of the world in the form of the Millennium Development Goals (MDGs), the Abuja Declaration and Framework for Action for the Fight Against HIV/ AIDS, Tuberculosis and other Related Infectious Diseases and statements from a host of other summits, conferences and special meetings. The UN declaration went on to describe the creation of a global HIV/AIDS and health fund with

financial support from “donor countries, foundations, the business community, including pharmaceutical companies, the private sector, philanthropists and wealthy individuals” (United Nations 2001, p. 14) for which a Transitional Working Group had been struck after a meeting of the Organization of African Unity Summit in Abuja earlier in the year (The Global Fund no date-a, p. 8). The concept of a fund had been endorsed at the previous year’s G8 Summit in Okinawa (G8 2000, ‘G8 Communiqué Okinawa 2000’) and in Genoa, Italy a month after Annan’s press conference the final Communiqué from the G8 Summit (G8 2001, ‘Communiqué Genoa July 28’) described the launch of what would become The Global Fund:

...we have launched with the UN Secretary-General a new Global Fund to fight HIV/AIDS, malaria and tuberculosis. We are determined to make the Fund operational before the end of the year. We have committed \$1.3 billion. The Fund will be a public-private partnership and we call on other countries, the private sector, foundations, and academic institutions to join with their own contributions - financially, in kind and through shared expertise.

Despite the rhetoric there was still some distance to go. The UN estimated that by 2005 \$9.2 bn a year would be needed to respond to the pandemic (Schwartlander et al. 2001, p. 3). It’s noteworthy that the United States’ founding commitment to Annan’s efforts was only \$200 mm or about 1% of its domestic spend on the disease (Schwartlander et al. 2001, p. 3; Dietrich 2007, p. 278). The recently elected President Bush was playing to conservative political and religious domestic politics emphasising prevention (including abstinence) over more expensive treatment and concerns that funds would not be well spent. Nevertheless it could be argued that the policy influence of the United States was felt in the Global Fund’s early days through the neo-liberal promotion of the role of the private sector and the situating of the Global Fund outside of the UN (Dobbin, Simmons



and Garrett 207, p. 457). It was not until 2003 that the United States announced its bi-lateral President's Emergency Plan for AIDS Relief (PEPFAR) with a commitment of \$15 bn over five years including authorisation to commit \$1 bn a year to the Global Fund (Dietrich 2007, p. 280; Lisk 2010, p. 95). By this time, with the controversial engagement in the Iraq war at hand, the HIV/AIDS agenda took political moral ground as "a work of mercy beyond all current international efforts to help the people of Africa" (The Guardian 2003, 'Saddam is 'Deceiving, Not Disarming''). As noted in Chapter 3, the United States went on to become the largest donor to the Global Fund over its short history and consequently its influence has become far more direct.

2001 then was an initiation, with world heads of state agreeing on a mechanism to respond to the HIV/AIDS pandemic and an initially modest commitment, particularly from the United States, of funds to this 'partnership' between public and private actors. Annan's feats of diplomacy and the G8's endorsement meant the Global Fund had a strong and wide base of political support from its inception and eventually the domestic politics of leading donor nations, particularly the United States, caught up.

### The Global Public Goods' Nature of Fighting Infectious Disease

Diplomacy and politics were not the only factors which laid a foundation for the creation of the Global Fund. In the late 1990s the UN through the UNDP fostered a discourse on globalisation, international cooperation and global public goods.<sup>3</sup> This discourse placed considerable focus on health and its financing moving health into the domain of other global concerns such as security and the environment. In the first of several volumes on global public goods edited by Kaul and her associates from the UNDP's Office of Development Studies, Chen, Evans and Cash (1999, p. 297) describe the case for health as a global public good:

Global health increasingly demonstrates cross-border externalities. As a public good, health risks and responses are increasingly global....Future international health cooperation will be influenced by at least three factors—resource mobilization, systems of global governance and the creation of institutional space for organizational renovation and innovation.

The global public goods discourse reinforced the prominence of health threats and challenges and underscored the multi-actor international cooperation required to address them (Kaul and Conceição 2006a, p. 35; Conceição 2006, pp. 274-5).

This theme of interdependency and its implications for health at global and country levels was not new (for example, Walt 1998; Yach and Bettcher 1998a and 1998b); however, what was new was the role of private actors in what had been treated almost exclusively a public domain. Positioning health as a global public good provided a theoretical framework to argue that the financing and delivery of global public goods was no longer exclusively a public function, but an undertaking of both public and private actors, an opening up of traditional multilateralism: "...this growth of private involvement in the international public arena has been supported by bilateral, multilateral, and private donors who have become increasingly disappointed in purely state-led or market-led approaches..."(Forman and Segaar 2006, p. 216). The global public goods discourse paved the way for embracing new notions about the intersection between public and private spheres in global public health, diffusing an agenda with neo-liberal resonance (Dobbin, Simmons and Garrett 2007, p. 457) and prophesising (Chen, Evans and Cash 1999, p. 297) the creation of the Global Fund, a new type of international organisation which sought to bring together the public and private spheres to fight the three infectious diseases identified in MDG 6.

## Increased Funding for Health

In the 1990s, the World Bank arguably had the most influence on health of any of the multilaterals including the WHO (Koivusalo and Ollila 1997, p. 85; Kickbusch 2000, p. 982; Lee 2009, pp. 82, 84). The World Bank (1993, p. 165) estimated that by 1995 it would be the “largest single source of external funding for health” among multilaterals and its 1993 World Development Report, *Investing in Health*, laid out the Bank’s economic approach to health and health financing. A departure from the WHO’s Alma Ata declaration (WHO 1978, p. 1) that health is a “state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, [and] is a fundamental human right”, the World Bank’s *Investing in Health* (1993, p 6) prescribed an economic approach. Its key messages were cost-effective public expenditure supported by decentralisation and contracting out, public financing for a “minimum package” of clinical services, and public and private sector competition for the provision of other health services such as drugs. *Investing in Health* introduced the use of the disability adjusted life year (DALY) as a measure of the global burden of disease and the effectiveness of health interventions at reducing the disease burden, linking cost effectiveness with measures of morbidity and mortality (Abbasi 1999, p. 1005). Health was subject to decisions about allocative efficiency—how to allocate scarce resources to meet system goals—and technical efficiency—how to manage delivery of allocated resources more cost effectively. The WHO’s human rights framing of health had been displaced by an economic rationale and a neo-liberal ethos.

By the millennium, the WHO was building on the World Bank’s neo-liberal economic framing of health making a case for economic development through increased health investment. In December 2001 Gro Harlem Brundtland, then Director-General of the

WHO, received the *Report of the Commission on Macroeconomics and Health*, chaired by Jeffrey Sachs. The Commission's report made the case for the link between health and poverty alleviation and proposed a nine item action agenda to meet the MDGs which was predicated on scaling up health funding from donors, public-private partnership funds and pharmaceutical companies. The Commission recommended that governments increase spending on health projecting that US\$30 to \$40 per capita in health financing was required to address health challenges in developing countries. It estimated that at the time spending was between US\$13 per capita for least developed countries and US\$24 per capita for other low income countries (WHO 2001a, p. 16). It recommended that donors, rather than private sources, close this significant gap in conjunction with efforts from developing countries themselves. In addition to recommending donor and developing country financing targets, the Commission advocated for the creation and financing of The Global Fund (WHO 2001a, pp. 27-8). The Commission made the economic case that significant new resources were needed if the health MDGs were to be realised and donor governments would be on point to provide them.

The WHO's case for increased funding for health and global advocacy efforts for new funds for HIV/AIDS resulted in significant commitments which fundamentally changed the positioning of global public health. The World Bank launched its Multi-Country HIV/AIDS Program (MAP) for Africa in 2000 which recognised the urgency and exceptionality of HIV/AIDS and led to the "adoption of flexible approval arrangements and less stringent eligibility criteria for MAP funding" (Lisk 2010, p. 103). Lisk (2010, p. 78) estimates that through the MAP the World Bank contributed more than US\$1.5 bn to 40 low and middle-income countries between 2000 and 2010. The Global Fund approved its first grants in 2002, and as mentioned in the previous section, in 2003 the United States Congress passed the "U.S. Leadership Against AIDS, Tuberculosis and Malaria Act",

which was to become PEPFAR. New resources for HIV/AIDS were made available at an unprecedented scale.

The ground had been prepared for the emergence of the Global Fund politically and diplomatically through the UN and the G8, discursively through positioning health as a global public good, backed by a neo-liberal economic rationale that argued for an increased investment in health, one that could be managed and measured. At the same time significant new funding sources to combat HIV/AIDS were made available. Global public health and HIV/AIDS in particular had moved decisively out of the realm of national social policy and onto the world stage, the subject of high politics and in the interests of the world's wealthiest and most powerful states.

### **3. Opening the Door to Private Actors**

#### The UN and the Private Sector

The UN system through its discourse on global public goods described the cooperation between public and private actors needed to address global health challenges. To consider the UN's relationship with the private sector, it is necessary to consider what the UN views as constituting what Forman and Segaar (2006, p. 208) describe as private actors in public spaces. It is best to say at the outset that an accepted wisdom or seminal definition of what constitutes private actors including civil society and the more challenging notion of global civil society are elusive and the ideas remain deeply contested.<sup>4</sup> Nevertheless, although the UN (1999, p. 1) has acknowledged ambiguity in its definition of the private sector, the Joint Inspection Unit's 1999 report on the involvement of the private sector with the UN (1999, p. 1) defined it as a component of civil society which encompasses "members of the business community (from small and medium-sized enterprises to major multinational corporations and including the informal sector) and their representatives (who may act

through not-for profit associations or organizations such as Chambers of Commerce or philanthropic Foundations).” This definition excludes NGOs.

The definition of private sector in the 2004 Cardoso report on civil society relations with the UN (2004, p.13) was consistent with the Joint Inspection Unit’s 1999 version, although it did acknowledge “boundaries between the actors are porous” noting particular questions of whether or not private foundations, internet-facilitated communications and small and medium-sized enterprises supported by governments or NGOs are private sector when they demonstrate civil society characteristics. Therefore, while there is no one, accepted UN definition of the private sector, it can generally be taken to mean from the UN’s point of view firms of all sizes and their representatives excluding NGOs. Later sections of this chapter will address private actors outside of these UN definitions including civil society and its role in public health implementation and private foundations, in particular the Bill and Melinda Gates Foundation.

A strong rationale used by the UN to promote cooperation with the private sector was its own resource and capacity constraints. In preparation for the UN Millennium Summit held in September 2000, the Secretary-General (2000c, p. 40) released *‘We the Peoples’: The Role of the United Nations in the 21<sup>st</sup> Century* which stated that the UN “has increasingly been required to do more with less. This, in turn, has required greater collaboration between our agencies and more partnerships with actors in civil society and the private sector.” The Millennium Declaration which arose from the summit underscored this intent and in December of the same year, the UN adopted a resolution *Towards Global Partnerships* which acknowledged that efforts to meet the challenges of globalisation could “benefit from enhanced cooperation between the United Nations and all relevant partners, in particular the private sector, in order to ensure that globalization becomes a

positive force for all” (United Nations 2000a, p. 1). While it was clear from the UN’s point of view that it could gain new resources, financial and otherwise from partnerships with the private sector, it was less clear, or at least not well articulated what the private sector’s interests might be, the magnitude of its contribution or extent of its involvement and whether or not private interests could align with the UN’s vision for the positive forces of globalisation.

The resolutions adopted by the UN General Assembly at the beginning of the millennium reflected the UN’s interest in working with the private sector.<sup>5</sup> In health, the examples are directed at the pharmaceutical industry and the benefits of public private partnerships. In *We the Peoples*, developed countries and the pharmaceutical industry were challenged to work together to find an effective and affordable HIV vaccine (United Nations 2000c, p. 28) and the Global Alliance for Vaccines and Immunization (GAVI) was cited as a model of what “innovative public-private partnerships, supported by public incentive systems, [to]... stimulate the increased investments...can achieve” (United Nations 2000c, p. 28). At the beginning of the millennium the UN had set itself formidable challenges in the form of the MDGs and had swung open the door to working with the private sector in order to achieve them.

The UN’s openness to increasing cooperation with the private sector created a tension which Slaughter (2004a, p. 169) described as a “merging and blurring of [the] lines of authority...[which] are ultimately likely to blur the distinction between public legitimacy and private power.” Bartsch (2007b, p. 3) identifies this tension between the public and the private in GHIs like the Global Fund, asserting that these partnerships,

...contribute to innovative and effective solutions to certain policy problems...[but] they are [also] associated with considerable challenges, as they

allow private interests to gain significant influence on processes of agenda-setting and policy-making in global health. The fact that non-state actors are not authorized to do so in the same way state actors are...challenges both the legitimacy of GPPPs [Global Public Private Partnerships or GHIs] and of the system of global health governance.

The issue of the dissolution of the liberal notion of legitimate public authority is discussed further in Chapter 6. The UN embraced the notion of working with the private sector and for organisations like the Global Fund this created a tension that persists.

### The Gates Foundation and the Power of Philanthropy

In the 1990s, one private actor appeared which has been especially influential in global health. The Bill and Melinda Gates Foundation (the Gates Foundation) was created in 1994 with an initial stock gift of approximately US\$94 mm (Bill and Melinda Gates Foundation 2009a, 'Foundation Timeline'). By 2009 the Gates Foundation had the largest endowment of any private foundation in the world and had distributed over US\$12 bn in grants to global health research and initiatives (Bill and Melinda Gates Foundation, 'Grants Overview', 2009b). To provide a point of comparison, in 2007 the amount spent by the Gates Foundation on global health was almost more than the WHO's entire budget (McCoy, Kembhavi, Patel and Luintel 2009, p. 1645).

The Gates Foundation derives its influence from the level of financing it provides and also through its strategic selection of recipients. For example, "ActionAid International received a grant of just under [US]\$11 mm to develop a network of non-governmental organisations to monitor and lobby European governments and the European Commission to support the right to health" (McCoy, Kembhavi, Patel and Luintel 2009, p. 1647). The WHO received 69 grants between 1998 and 2007 worth a total of US\$336 mm making the



Gates Foundation one of the biggest donors to the WHO, exceeding the contributions of most G20 governments (McCoy, Kembhavi, Patel and Luintel 2009, p. 1648). Some grants to the World Bank were channelled to other recipients, but others “seem to have been awarded to support World Bank activities related to disease control and health systems” and two grants were awarded to the International Finance Corporation (IFC), the arm of the World Bank that supports private sector development (McCoy, Kembhavi, Patel and Luintel 2009, p. 1648). The Gates Foundation has funded global health to effect change and achieve influence through multiple routes.

All the key contributors to global health have an association with the Gates Foundation through some sort of funding arrangement. Coupled with the large amount of money involved, these relations give the foundation a great degree of influence over both the architecture and policy agenda of global health. Through its funding of NGOs and policy think tanks, the foundation also confers power and influence on select organisations and in doing so, establishes some leverage over the voice of civil society (McCoy, Kembhavi, Patel and Luintel 2009, p. 1650).

In addition to the level of financing it provides and its strategic selection of recipients, the third way the Gates Foundation asserts its influence is through governance. It has a seat on many of the boards of directors<sup>6</sup> of the organisations in which it has invested. This includes the Global Fund to which the Gates Foundation pledged US\$100 mm in June 2001 just ahead of the G8 Summit which endorsed the Global Fund’s creation (United Nations Foundation 2001). It has also been involved in setting the agenda of the G8 (McCoy, Kembhavi, Patel and Luintel 2009, p. 1650) and it participates in a group known as the Health Eight (H8) which includes the WHO, the World Bank, GAVI, the Global

Fund, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), and UNAIDS.

Few discussions of how networks function for advocacy, knowledge or policy take into account such a deliberate, consistent and multi-pronged effort by a private actor who also brings considerable resources. Keck and Sikkink (1999, p. 100) describe interactions among participants in transnational advocacy networks that result in mutual transformation. Benner, Reinicke, Witte and Martin (2004, p. 197) argue that while these networks raise questions about accountability, they have created “new venues for participation beyond the closed shops of the ‘club model’ of international cooperation.” However, the purposeful engagement of the Gates Foundation is closer to the ‘club model’ of behaviour than Benner et al. concede. Stone (2002, p. 8) observes that, “[n]etworks behave in a ‘clublike’ fashion. Elitism, gate keeping and the domination of certain interests are tendencies that undermine the inclusion of new voices in networks. Participation is dependent on cognitive resources, expert status or professional experience.” In the case of the Gates Foundation, it is not just its expertise that wins influence, as other private foundations which have been active in global health for many decades like the Rockefeller Foundation also have expertise. Rather, its level of financing, its granting and investment strategy and its governance role have succeeded in making it a uniquely influential private actor, one that shapes the global health agenda, acts on civil society as well as multilateral leaders and distinguishes itself from the traditional patron role that many private foundations have played.

#### Civil Society and ‘the Thousand Points of Light’

Historically as alluded to in the previous section, the concept of civil society has changed relative to “the different ways in which consent was generated in different periods, and the

different issues that were important at different times” (Kaldor 2003, p. 585). The rich historical, cultural and epistemological debates on the meaning of civil society and the meaning of global civil society remain deeply contested and will not be explored or resolved in this thesis (see p. 60), but some conception is needed for the purposes of discussion and analysis. Does civil society refer to nationally based non-state organisations such as trade unions, schools, churches and clubs, or does it refer to international organisations which participate in trade and markets (Kumar 2007, p. 417)? Is civil society a process of activism where “...individuals negotiate, argue, struggle against or agree with each other and with the centres of political and economic authority” (Kaldor 2003, p. 585), or is it a neoliberal conception where “both ‘insiders’ like NGOs and ‘outsiders’ like social movements” gain access to power (Kaldor 2003, p. 590)? The answers to these questions where this thesis is concerned is, perhaps unhelpfully, ‘yes’. As will be discussed in the next section and in Chapter 3, the Global Fund’s country level governance model in particular engages a range of non-state actors in health care delivery but agenda setting remains in the hands of the elite. Similarly, as discussed in Chapter 4 international NGOs like Médecins sans Frontières have and continue to play a significant role in the market for essential medicines like anti-retrovirals, facilitating their affordability by and availability in developing countries. The discussion later in this section and in Chapter 4 will highlight the significant activist role of non-state actors in changing policy related to HIV/AIDS both that of governments and international institutions such as the World Trade Organization (WTO). And lastly as discussed in detail in Chapter 3, the Global Fund’s global level governance model is an example of a “respectable” (Kaldor 2003, p. 590) neoliberal concept of civil society where among the non-state delegations on the board, one represents people living with or in communities affected by HIV/AIDS, tuberculosis or malaria. What can be taken from these examples is

that interpretations of civil society are fluid (Zürn 2002, p. 248); nevertheless, civil society is interwoven in the Global Fund's governance and intrinsic to global and country level HIV/AIDS responses.

Given this 'fluidity' it is no surprise then that policy makers have struggled to define this social force with which they engage. The WHO (2001b, p. 3-4) in its 2001 discussion paper on the role of civil society in health offered its version:

In the absence of common understanding or definition, civil society is usually understood as the social arena that exists between the state and the individual or household. Civil society...provides the social power or influence of ordinary people...Within this social domain, individuals and groups organize themselves into civil society organizations (CSOs) to pursue their collective interests and engage in activities of public importance...CSOs are broadly understood to be non-state, not-for-profit, voluntary organizations. In reality, however, there may be state or market links to CSOs that blur the borders...States or the private for-profit sector may play a key role in the establishment of some CSOs or provide significant funding, calling into question their independence from the state and private sectors...Non-governmental organizations (NGOs) are considered part of civil society and the term is often used interchangeably with the term CSOs, particularly in the health sector.

The WHO's definition includes almost every type of non-state activity, but it does not allude to what scholars variably call "global civil society" (Keane 2001, p. 23; Kaldor 2003, p. 596; Kumar 2007, p. 414), or "transnational networks" (Keck and Sikkink 1999, p. 90), or as Castells claims, a type of international public sphere which exists "within the political/institutional space that is not subject to any particular sovereign power but,

instead, is shaped by the variable geometry of relationships between states and global nonstate actors” (Castells 2008, p. 80). Piot et al. (2008, pp. 852-3) point to the complexity that this rich diversity brings to HIV/AIDS prevention in particular:

...the challenge has been to join these efforts [to address HIV/AIDS prevention] into a coherent movement that is able to shift social norms and sexual and drug-use practices. Instead, the demands of these sectors have been competing or contradictory: community versus state, religious versus secular, local versus international, private versus public and medical versus social.

Civil society then, particularly related to HIV/AIDS, inhabits a social arena between the state and individual and national and international spheres. Its inherent diversity means that it cannot be taken to be a cohesive whole, but rather a diverse and loose collection of non-state actors with varied ideologies and interests relative to the political authority of the state and international institutions and the economic authority of the market.

Civil society has long had a role in country level health care service delivery. Boone and Batsell (2001, p. 13) describe the rise of civil society in health, and in particular health service delivery, as a product of neo-liberal structural adjustment policies:

In the 1980s, proponents of structural adjustment and state shrinking embraced voluntary associations as "the thousand points of light" that could help supply the social services and safety nets the state could no longer afford to provide. Across the [African] continent, NGO service providers began to solicit and receive direct funding from official and non-governmental international agencies. "Development funding" bypassed states and went directly into the hands of local, decentralized, citizen-controlled organizations.

This role was evident in Malawi where the Christian Health Association of Malawi (CHAM), a collection of faith-based, private charities provides 26% of the country's health services (Carlson et al. 2008b, p. 24). CHAM is just one slice of non-state actors engaged in implementing Malawi's HIV/AIDS response primarily as sub-recipients of Global Fund grants which also includes professional associations, associations for people living with disease, business associations and a range of national and international NGOs (the roles of these actors are described in Chapter 4).

The engagement of civil society in health service delivery has been a critical element of many countries' scaled up response to their HIV/AIDS epidemics, featuring strongly not only because CSOs offer capacity and community reach but also because they advocate for the rights of those affected by the epidemic (Teixeira, Vitoria and Barcarolo 2004, p. S6; Piot 2005, p. 13; The Global Fund (no date-a), p. 39; Piot, Bartos, Larson, Zewdie and Mane 2008, p. 854; Doyle and Patel 2008, p. 1931). The Global Fund, for example has disbursed approximately 40% of its grants to civil society including NGOs, faith based and private sector organisations such as private foundations<sup>7</sup> providing resources to sustain these organisations and also legitimising the role they play. Critics argue that this 'bypassing' of government dilutes state influence with international organisations and undermines authority within its own borders (Doyle and Patel 2008, p. 1935). The role of civil society in health service delivery in developing countries is unlikely to diminish and national CSOs—although this was not in clear evidence in Malawi for this research—may contribute to national agenda setting and policy making. Practically, developing countries with weak health systems rely on CSOs to form part of the health system infrastructure for their HIV/AIDS responses which in turn facilitates CSOs' unprecedented access to funding.

Beyond the practical nature of civil society's involvement in health care, the HIV/AIDS pandemic has highlighted its powerful activism which has had a galvanizing, political effect. Peter Piot (2005, p. 11), Executive Director of UNAIDS from 1994 to 2008 noted that,

[t]he history of the pandemic shows that in virtually every country – rich, middling and poor – that has succeeded in curbing its epidemic, or shows the promise of doing so, it has been because of the interplay between activism and responsible governance. This is as true of the UK and the US as of Brazil and Thailand...And this is true too of the international response, whether in terms of action on treatment access, human rights or financing the response.

It is impossible in the confines of this discussion to do the global and national, developed and developing country and historic and present day landscapes of civil society activism justice. However, two brief examples related to HIV/AIDS follow for illustration. In the United States, ACT UP was an organisation rooted in the gay rights movement that gained prominence in the late 1980s when the epidemic in that country largely affected homosexual men. It is known for its slogan, "silence=death." ACT UP and organisations like it employed civil disobedience, public demonstrations, and informed discussions with decision makers to bring pressure to bear on researchers, health officials and pharmaceutical manufacturers to get access to drugs for HIV infected people before the Food and Drug Administration had completed its approval process, lower the cost of anti-retroviral drugs and secure a considerable allocation from Congress for AIDS research (Wachter 1992, p. 129). Several years later South Africa's Treatment Action Campaign succeeded first against pharmaceutical manufacturers to allow parallel imports<sup>8</sup> of anti-retroviral drugs and second against its own government to provide access to anti-retroviral therapy for mothers to prevent transmission to newborn children and subsequently for

people living with HIV/AIDS (Friedman and Mottiar 2005, p. 514). Treatment Action Campaign used the courts, public demonstrations, disobedience and its connections to South Africa's powerful trade unions to overcome a climate of fear and denial including opposition from the country's President. Piot et al. (2008, p. 852) note that "over the history of HIV/AIDS, political processes have often come together to create a mass popular demand...[and]...In many instances, this demand has coincided with periods of social and political transformation." ACT UP and Treatment Action Campaign are only two of many examples in countries throughout the world where civil society activism related to HIV/AIDS has achieved significant political change.

The Global Fund involved civil society from its inception (The Global Fund no date-a, p. 8) although as discussed in Chapters 3 and 5 arguably agenda setting remains in the hands of the elite. The Global Fund credits civil society's HIV/AIDS advocacy campaigns with helping to secure a four-fold increase in funding from multilateral and bilateral international organisations and donor governments between 2001 and 2006 to fight the disease (The Global Fund no date-a, p. 8). It also claims that civil society's role in the design of the Global Fund "led to a sense of ownership; the Global Fund was an initiative that they had helped to create, fund and govern" (The Global Fund 2011a, 'Civil Society and the Private Sector'). Civil society's role in global public health and the response to the HIV/AIDS pandemic in particular has had wide reaching effects both practically in terms of its role as a provider of treatment and care as part of the health system infrastructure in many developing countries and politically in terms of its successful activism on a global scale.

#### The Virtue of Independence and a Bias for Action



It is possible that the many factors that provided the opportunity for the Global Fund's creation—the broad political support from the UN and the G8, the recognition that fighting infectious disease is a global public good requiring international cooperation among public and private actors for its provision, the call for significant increases in donor government financing for global health, the availability of and influence associated with new sources of private funds to fight HIV/AIDS, tuberculosis and malaria and the pivotal role of civil society--could have resulted in a new unit or programme under an already existing global health organisations such as the WHO or UNAIDS. Instead, the UN and donor governments chose to create a constitutionally private and independent organisation outside of the UN system and the Bretton Woods Institutions.<sup>9</sup> There was a desire to create a new mechanism for global health with an operational model that borrowed from the private sector while maintaining public characteristics. Buse and Walt (2000a, p. 551) note that one factor which made a public/private partnership model attractive was the “growing disillusionment with the UN and its agencies.” Kickbusch (2009, p. 323) cites the erosion of trust in the effectiveness of the WHO and Buse and Walt (2000a, p. 552) describe the perception that “[p]artnerships that are housed outside the UN bureaucracy are viewed as a way of getting things done, and, when industry is involved, getting things done efficiently.” There was belief in the virtue of independence from the UN and that ‘privateness’ lent a bias for action.

The lack of confidence in traditional multilateral organisations was reflected in the principles that emerged from consultations by the Global Fund's Transitional Working Group in 2001.<sup>10</sup> This included linking resources to the achievement of results (now known as performance-based funding) and breaking from “business as usual” to make more efficient use of donor resources, with lower transaction costs (WHO 2002, p. 1). The Transitional Working Group was established in July 2001, the board of the Global Fund

had its first meeting in January 2002 and the first round of funding for US\$565 mm for 55 programmes in 36 countries was approved in April 2002. The Global Fund moved quickly to set up its governance and become operational. Its 'private' nature was evident in its initial constitution and in the expectations it set for efficiency which helped it to mobilise donor support and set it apart from the negative attributes associated with the slow moving bureaucracy of UN organisations.

The new millennium saw a transformation in how the international system addressed global public health concerns. A confluence of events including political support, a global public goods discourse underpinned with a neo-liberal economic framing and an unprecedented scale of new resources which were made available for HIV/AIDS in particular prepared the ground for the emergence of the Global Fund self-described as a public/private partnership. The next section will describe the Global Fund as a form of institutional innovation among traditional multilaterals with specific reference to the WHO.

#### **4. Creating an Innovative International Institution**

The Global Fund's design is a form of institutional innovation which distinguishes it from most GHIs and also from traditional multilaterals like the WHO. Taken together, the Global Fund's global and country level governance models, its modus operandi of transparency and performance-based funding, its unprecedented resource mobilisation and distribution and finally its initial, vertically focused mandate comprise its unique design and its strategic strength. As a result, the Global Fund stands apart from traditional multilaterals even though it operates among them; moreover, as will be argued in subsequent chapters of this thesis, the Global Fund's design provides new sources of legitimacy, underpins its accountability mechanisms and ultimately contributes to its

growing authority at global and country levels. The Global Fund is a form of institutional innovation which has disrupted the multilateral order particularly where health is concerned, belying its modest inception as a GHI intended to serve as a financing mechanism for MDG 6.

### Governance Beyond States

The WHO, UNAIDS and the Global Fund form a continuum of departure from a traditional multilateral ‘states as members’ governance model. In the section that follows, the original constitution of each institution will be briefly described followed by a comparison of the WHO and the Global Fund’s governance models at global and country levels.

The WHO, the most traditional among the three organisations, is constituted as an UN organisation and is governed by a ‘one member, one vote’ model among states which comprise its overarching governing body, the World Health Assembly. At global level, UNAIDS occupies a middle ground. The UN Economic and Social Council (ECOSOC) is UNAIDS’ parent organisation and it functions as a partnership of UN organisations, referred to as co-sponsors, the initial six of which included: the WHO, UNICEF, the UNDP, the UNFPA, the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the World Bank. Added to these original cosponsors are the United Nations Commissioner for Refugees (UNHCR), the International Labour Organization (ILO), the United Nations World Food Programme (WFP), and the United Nations Office on Drugs and Crime (UNODC). UNAIDS is also an organisation with controversial beginnings. It was created in 1996 by moving the Global Program on AIDS out of the WHO. As Lee (2009, p. 62) notes, “[f]or the WHO, the creation of UNAIDS was an

institutional “slap in the face,” an expression of the loss of faith by donor governments in the organization’s capacity to lead a global disease campaign.”

The Global Fund’s original constitution departs from the traditional multilateral WHO and the quasi-multilateral UNAIDS. The Global Fund was originally constituted as a private foundation in Switzerland and acquired “international juridical personality and legal capacity” in 2004 (The Global Fund 2004, p. 2)--status as an international organisation--even though its governance model at both global and country levels diversifies participation beyond states and beyond the UN system.<sup>11</sup> As was discussed earlier in this chapter, disillusionment with the UN system and the WHO and a desire to get things done efficiently and quickly underpinned the Global Fund’s independence (Buse and Walt 2000a, p. 551 and 552; Kickbusch 2009, p. 323), echoing some of the dissatisfaction surrounding the founding of UNAIDS.

The composition of the Global Fund’s board makes evident its intention to diverge from the ‘states as members’ traditional multilateral model of the WHO (see Chapter 3 for a discussion on the Global Fund’s inclusive governance as a source of legitimacy). It includes delegations representing state and non-state actors such as donor countries, recipient countries, developing country NGOs, developed country NGOs, the private sector (in this case meaning for-profit business and corporations), private foundations and people living with or communities affected by HIV/AIDS, tuberculosis or malaria. Among the non-state actor delegations at the end of 2010 were NGOs such as the African Council of AIDS Service Organizations (AfriCASO) representing the developing country NGO delegation, the Bill and Melinda Gates Foundation representing the private foundation delegation, and the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria representing the private sector delegation. In addition, non-voting members included the

WHO, UNAIDS, the World Bank (the Global Fund's trustee), a representative of the Global Fund's partner constituency, its Executive Director and as required to maintain its legal status in Switzerland, a Swiss law firm. The Global Fund's inclusion of non-state actors in its global level governance and their diversity distinguishes it from a traditional multilateral and reflects what Kaldor (2003, p. 590) might describe as a "respectable" neo-liberal engagement of civil society where activist groups gain access to power.

Even though both the WHO and the Global Fund are global health organisations operating in the multilateral order, they have different governing models 'below' global level particularly with respect to the WHO's regional structures and the Global Fund's country level governance. The WHO has a country presence through its country offices which report to a Regional Director. In the case of the WHO, its constitution sets out its regional structure and the policy making role of the six regional offices. As Lee (2009, pp. 31-2) describes, in practice this regional structure creates a second organisational entity under the World Health Assembly rather than one organisation aligned at global level:

The six regional offices of the WHO are somewhat unique within the UN system in their degree of independence and decision-making power. Regional committees meet annually to formulate policies with a regional dimension, review the regional program budget proposed by the Regional Director, and monitor the WHO's collaborative activities for health development in that region. In principle, decisions are then formally approved by the WHA [World Health Assembly] and the Executive Board to ensure that they are appropriate to global policies. In practice, the agendas of these bodies have grown to such an extent that tight policy and budgetary control is not possible. This has given Regional Directors and committees considerable discretion over their activities.

The WHO's constitution created a management challenge by granting regions the authority to set policy and report directly to the World Health Assembly, bypassing the WHO secretariat.

The Global Fund has a significantly different country governance model, notably because unlike the WHO and Bretton Woods Institutions, it includes non-state actors and, rather than being a form of in-country Global Fund representation similar to the models of the WHO and UNAIDS, it is independent. The Global Fund describes its country level governance model as 'country owned' (see Chapter 5 for a detailed discussion of 'country ownership' and its practice in Malawi). At its core are the Country Coordinating Mechanism (CCM), Principal Recipients and a Local Fund Agent none of which are part of the Global Fund organisation proper. The Global Fund requires a CCM to develop and make applications to the Global Fund and to oversee the Principal Recipients' implementation (The Global Fund, no date-b, p. 2). The Global Fund's CCM guidelines encourage CCMs "to be broadly representative of all national stakeholders in the fight against the three diseases", and goes on to say that "[t]he role and function of each player within the partnership of the CCM will be agreed on by the mechanism" (The Global Fund, no date-b, p. 3). Given this flexible and deliberately non-prescriptive guidance it is therefore not surprising that Shakow (2006, p. 25) found that,

[i]n practice, CCM leadership, composition and practices have varied widely, and they have had a mixed record of effectiveness... So while they were designed to help increase public participation, and in some cases have done so, in other instances they are considered a "real headache" that fragments the management of AIDS and broader health work in-country and creates a time-consuming "talk-shop."

If a grant is approved, the Global Fund enters into a Grant Agreement with a Principal Recipient and contracts with a Local Fund Agent in an audit function to monitor, verify and report on grant performance. The fact that CCMs, Principal Recipients and Local Fund Agents perform governance functions but are not part of the Global Fund itself, and the intent in the case of CCMs that they engage actors from the state and non-state and national and international spheres to create a national forum to address the three diseases is clearly quite different from the WHO's more traditional model of regional and country presence with formal reporting lines to the World Health Assembly.

On the one hand the Global Fund's inclusion of non-state actors at global and country levels and the independence of its in-country governance could be seen as providing a more participative model of engagement and oversight beyond that of the state. On the other hand, as will be discussed further in Chapters 3 and 5, the 'national public sphere' created by the Global Fund's country level governance model takes on an elite identity. In addition, as will be discussed later in this chapter, the Global Fund's lack of country presence creates practical challenges for its partners whose staff provide considerable technical assistance to CCMs to prepare applications and report on performance. The Global Fund's departure from the WHO's more traditional 'states as members' model creates all the problems that Slaughter (2004a, p. 169) and Bartsch (2007b, p. 3) raised when they described the lines between public legitimacy and private power as blurred.

### Transparency and Performance-Based Funding

The Global Fund has adopted a transparent and performance-based 'modus operandi' (The Global Fund 2010c, 'Global Fund Principles'). (Chapter 3 offers a discussion on the Global Fund's transparency and performance-based funding as sources of legitimacy).

When the Global Fund was first established, it set new standards for both transparency and

performance-based funding among multilaterals. Its website remains a public accounting of its decision making and grant performance that few imitate. In their analysis of the interplay between transparency, participation and accountability of the international economic organisations, Woods and Narlikar (2001, p. 575) note a dramatic increase in information sharing by these institutions particularly through their websites, although the authors caution that increased information sharing does not constitute increased accountability. Transparency in the case of the Global Fund complements a normative conception of its 'publicness' as an international institution delivering a global public good. However, as Woods and Narlikar point out, transparency is not the same as a formal mechanism that holds the Global Fund to account either to donors, to grant recipients or to those whose lives it affects.

Together, the Global Fund's transparency and performance-based funding approach perform a compelling communication and advocacy function, particularly to donors. As one Global Fund Executive (2009, interview, Geneva) observed, "[t]he Global Fund achieves concrete results which are easier to communicate to donors and to the media. It's something that every [donor] Ministry can easily communicate to the public... it is a success story that you may want to be associated with... This is quite significant for donors." Buse and Harmer (Buse and Harmer 2007, p. 261) citing Lele et al. (Lele et al. 2005, p. xxii) note the role that communication has in resource mobilisation and allocation:

GHPs [Global Health Partnerships or GHIs] have been successful in raising the profile of certain diseases on policy agendas by concentrating on brand-building and public relations. They have been able to mobilise funding commitments by allocating proportionately more resources to advocacy and communications than conventional international health organisations... Consequently, public attention to problems of global health is at an all time high, and significant additional resources



have been generated for efforts to combat communicable diseases and to stimulate the development of new products.

The Global Fund's transparency and its performance-based funding ethos are an element of its design that underpin its resource mobilisation and therefore provide significant strategic value.

The Global Fund embedded tracking of and reporting on the performance of its grants from inception. The Global Fund describes its 'virtuous cycle' as 'raise it, invest it, prove it'. The Global Fund is not the only international organisation to adopt a performance-based approach but it provides an extremely successful example for using it to make a case to donors and is credited in some instances with improving country capacity to track and report on results (Brugha et al. 2004, p. 100; Bartsch 2007a, p. 160; Lorenz 2007, p. 567; WHO 2009, p. 2154). The Global Fund maintains that grant performance targets are 'owned' by the country, not the Global Fund:

Importantly, performance-based funding is based on radical country ownership of targets and implementation, with limited interference by the Global Fund as the donor. Implementation plans and targets are proposed by countries (with no formal involvement of the Global Fund), agreed upon by representatives of government, civil society, and people affected by the diseases in country (as part of a country coordinating mechanism), and reviewed by an international technical review panel. Performance is measured against what is realistic to achieve in country in a specific timescale (Low Beer et al. 2007, p. 1309).

The success of the Global Fund's 'raise it, invest it, prove it' model is in part due to the vertical nature of its mandate. As the Global Fund expands beyond this initial focus,

‘proving it’--as is discussed in the next section on the scope of the Global Fund’s mandate--will become a more challenging task.

The WHO also tracks performance linking its strategies to indicators and resources against which it reports (WHO 2008d). However, the nature of its operations--some of which have challenging-to-communicate outcomes related to technical standards, research or advocacy--and the fact it reports on its own performance rather than that of grantees, does not always lend itself to the same type of communication engaged in by the Global Fund. For example one of the WHO’s indicators in its Medium Term Strategic Plan 2008-2013 is the “number of new or updated global norms and quality standards for medicines and diagnostic tools for HIV/AIDS, tuberculosis and malaria” (WHO 2008d, p. 122). While a critical function, from a communications standpoint it may be challenging to convey success against this standard outside of the organisation. Compare this to the Global Fund’s reporting of the collective results of its grant recipients that “by the end of 2008 there were two million HIV-positive people receiving lifesaving ARVs [anti-retrovirals] (an increase of 560,000 from December 2007)” (The Global Fund 2009c, no page). While both organisations use a performance management approach as a tool of ‘good governance’, the Global Fund is accomplished at using this aspect of its operations to communicate its recipients’ accomplishments and in turn support its resource mobilisation efforts.

Although the practices of transparency and performance-based funding contribute to accountability, as Woods and Narlikar (2001, p. 575) point out they are not enough to constitute it. Rather, the Global Fund’s adoption of its distinct *modus operandi* and its ability to set new standards in this regard among multilateral organisations is a form of institutional innovation and one with clear strategic value. As will be discussed in Chapter

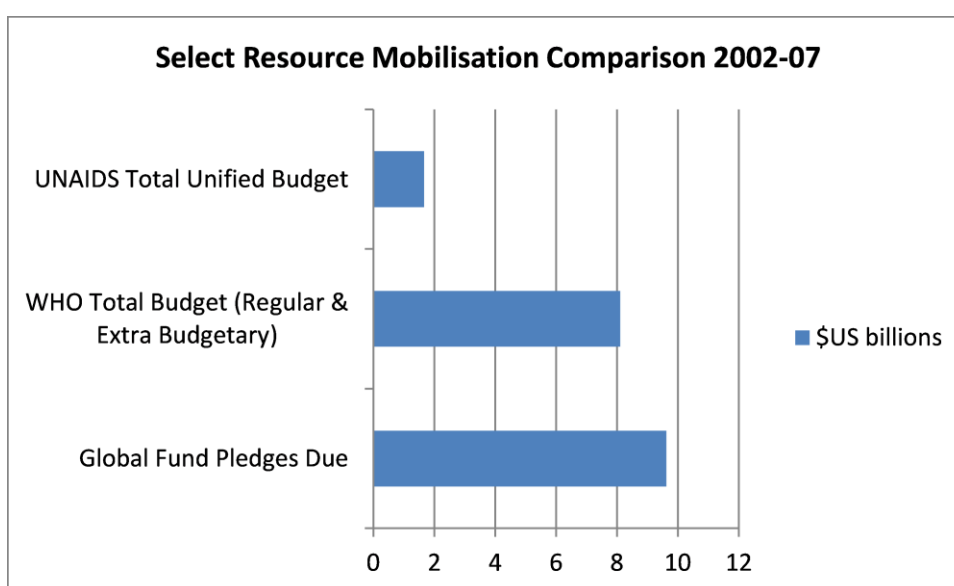
3, this *modus operandi* is also closely linked to the Global Fund's legitimacy and its capacity to legitimise (Barker 2000, p. 9; Baumgartner and Jones 2009, p. xx). It is difficult for the WHO and indeed for most multilaterals to imitate the Global Fund in this regard because their organisations and scope are more complex than the Global Fund's original mandate as a financing mechanism for three diseases. As the Global Fund expands its scope and deepens its own complexity, measuring and communicating its 'raise it, invest it, prove it' successes are likely to become more challenging.

### Unparalleled Resource Mobilisation and Distribution

The scale of the Global Fund's resource mobilisation and distribution is unparalleled (see Chapter 3 for a discussion on the Global Fund's resource mobilisation as a source of legitimacy). The Global Fund has made more resources available to combat HIV/AIDS, tuberculosis and malaria than any other UN or Bretton Woods Institution. Figure 1 shows the resources available to the Global Fund, the WHO and UNAIDS in the 2002 to 2007 period and although the figures are not directly comparable, they do provide a sense of relative scale (see p. 273 for a more detailed accounting and comparison). As Figure 1 shows, between 2002 and 2007, the Global Fund received pledges totalling approximately US\$9.62 bn to fight three diseases. Of that it disbursed approximately US\$7.82 bn. In the same period, the WHO's entire budget for all programmes, of which nearly half is spent on personnel, was approximately US\$8.10 bn (WHO 2008d, p. 3). UNAIDS, a UN organisation which is the main advocate for global action to fight HIV/AIDS and related diseases such as tuberculosis, had a total unified budget between 2002 and 2007 (a budget comprised of commitments from its UN partners, including the WHO, and the World Bank) of just US\$1.66 bn. The only fund of comparable size to the Global Fund is the bilateral U.S. PEPFAR which describes itself as "the largest commitment by any nation to

combat a single disease in history” (PEPFAR 2010a, ‘About PEPFAR’). PEPFAR disbursed US\$12.66 bn in the period 2004 to 2008, of which US\$2.76 bn went to the Global Fund (PEPFAR 2010c, ‘Summary Financial Status’). The scale of resources committed by donor governments collectively and the U.S. government’s unprecedented funding through PEPFAR means that more resources than ever before have been disbursed to countries not just for health but for the three diseases highlighted in MDG 6 and particularly for HIV/AIDS. The Global Fund might be similar to PEPFAR in magnitude of funds raised and disbursed, but its multilateral character is distinct from PEPFAR’s bilateralism, its sources of funds and their governance broader.

**Figure 1: Select Resource Mobilisation 2002-07 (based on figures from p. 273)**



The Global Fund and the WHO have very different mandates and models but they do have in common their primary source for resources: donor governments. Although the Global Fund describes itself as a public/private partnership, from a resource perspective it relies heavily on public sources. Through to 2010 donor governments contributed 96% of the Global Fund’s pledges (The Global Fund 2010e, ‘Our Resources’). The WHO relies on its member states for its assessed funds which in 2006-2007 comprised approximately 25% of its budget (WHO 2008c, p. 3). The remaining 75% of its budget in this period was

comprised of resources mobilised from: member states (51.5%), UN and intergovernmental organisations (25.2%) and the remaining 23.3% from a combination of the private sector, NGOs, foundations, local governments, supply of services funds and interest income (WHO 2008c, p. 5). The WHO then, like the Global Fund, relies on fundraising and donor governments in particular for its budget and programmes.

Ravishankar et al. (2009, pp. 2121-2) argue that mobilising resources for health from donor governments is a competitive business, the implication being that the Global Fund's success is the WHO's failure:

The expansion of resources for global health especially in the past 10 years has been accompanied by a major change in the institutional landscape. Two new and large channels of resource flows, the Global Fund and GAVI, have attracted a growing share of funds, while the proportion of assistance going to UN agencies and development banks has decreased during this period... To sustain their present role, the UN agencies—especially WHO and UNICEF—have to compete with recipient countries, NGOs, and other organisations for available DAH [development assistance for health] funds. This steady shift to a competitive model of funding runs the risks of undermining their crucial role as trusted neutral brokers between the scientific and technical communities on the one hand, and governments of developing countries on the other.

The Global Fund's competitive edge over traditional multilaterals like the WHO in resource mobilisation and distribution lies in its innovative design. It is an organisation created to be a financing mechanism and its transparency and performance-based funding underpin the idea, or the image (Baumgartner and Jones 2009, p. 37) that donor governments' resources are used effectively in the fight against HIV/AIDS, tuberculosis

and malaria rather than being consumed by large bureaucracies with programme outcomes that are hard to isolate and measure.

### Staking a Claim beyond the Vertical

As its name suggests, the Global Fund's initial mandate was to fight HIV/AIDS, tuberculosis and malaria. This vertical focus distinguished it from the WHO's much broader mandate and the normative and technical roles the WHO fulfils on behalf of its 193 member states. However, both organisations are evolving. The WHO is flexing its convenorship muscle, engaging in sophisticated political negotiation of hard instruments in global administrative law and the Global Fund is expanding beyond its vertical programmatic interventions towards investing in health systems and a National Strategy Approach. Given these changes, a vertical versus a horizontal comparison between the two organisations falls short.

The WHO's activities serve its 193 member states which include developed country states and least developed country (LDC) states. The WHO is a normative and technical leader on global health issues, however, its most influential functions are arguably that of coordination and political persuasion. Although 22 functions for the WHO are laid out in its constitution (see p. 270 for a comparison of the WHO's constitution and the Global Fund's by-laws), debates about the WHO's mandate have occurred since its inception (Brown, Cueto and Fee 2006, p. 66; Lee 2009, p. 9): "...whether expressed in terms of social versus biomedicine, normative versus technical (operational) activities, or as priority setting amid limited resources, [different views about what the WHO should do have] ...remained a defining feature of policy debates within the organization" (Lee 2009, p. 21). The WHO's mandate and its strategies and programmes are not set in isolation. In addition to negotiating the priorities of its 193 member states the WHO must also consider

its role relative to a proliferation of other participants in global health (Dodgson, Lee and Drager 2002, p. 13; Abbott 2007, p. 7) including other UN agencies such as UNICEF, GHIs such as the Global Fund, private corporations such as pharmaceutical companies and a host of CSOs, each one with an agenda and many with competing interests.

Buse in his examination of infectious disease partnerships noted that “approximately half of the partnerships report adding value through the development of ‘norms and technical standards’. In other words, they are, to some extent, governing substantive issue areas which had in the past been the preserve of national policy or fallen under the remit of an intergovernmental organization, such as the WHO” (Buse 2004, p. 231). With this excess of specialist ‘leaders’ it is not surprising that the WHO performs an important coordinating role at global level.<sup>12</sup> Zacher and Keefe (2008, p. 97) observe that “WHO financial and material assistance programs are undoubtedly vital for the recipients, but what global intergovernmental bodies such as WHO contribute most to health assistance is their ability to facilitate dialogues and promote cooperation among governmental and nongovernmental actors.” Or, in the words of a UN Executive (2009, interview, Geneva) “[t]he WHO’s role, quintessentially, is not just to provide the technical support but also the convenorship that ensures buy in. So it’s managing both the political and the technical processes.”

Contrasting with the WHO’s broad programmatic scope and its convenorship is the Global Fund’s initial ‘vertical’ focus on three diseases. As a financing mechanism to address MDG 6, the Global Fund has been successful, but the feasibility and sustainability of investing only in disease programmes in countries with weak infrastructures has put pressure on this original mandate. The idea that the Global Fund would be involved in health systems was evident in its Framework Document (The Global Fund, no date-c, ‘The Framework Document, p. 4), but the board did not explicitly encourage funding proposals

for health systems strengthening until 2007 (The Global Fund 2007 ‘Sixteenth Board Meeting’) and its National Strategy Approach which strengthens the Global Fund’s health system funding platform was approved in 2008 (The Global Fund 2008, no page). (Chapter 6 discusses the Global Fund’s role in health systems strengthening and its National Strategy Approach as they relate to its growing authority at global and country levels).

Critics of diseased-focused GHIs cite a number of problems with a vertical approach including the inability of countries to absorb disease focused resources without technical support, duplication of processes at country level among GHIs and other donors, a lack of sustainability especially for long term needs such as the provision of anti-retrovirals, and the draining of resources from general health services such as child health and the prevention of diarrheal diseases (McKinsey 2005, p. 1; Shakow 2006, p. 36; Veenstra and Whiteside 2009, p. 311; Khoubesserian 2009, p. 287). In addition to the Global Fund’s Round 7 call for proposals which encouraged attention to health systems strengthening, in early 2009 the Executive Directors of the Global Fund and GAVI in a letter to Gordon Brown, then-Prime Minister of the United Kingdom and Robert Zoellick, then-President of the World Bank as Co-Chairs of the International Health Partnership (IHP+), indicated their intention “to begin jointly programming GAVI Alliance and the Global Fund to fight AIDS Tuberculosis and Malaria (GFATM) resources towards health systems strengthening” (Lob-Levyt and Kazatchkine 2009). The two organisations staked a claim beyond the vertical stating that they were “pathfinder organisations” and had become “leading investors in health systems” (Lob-Levyt and Kazatchkine 2009). A UN Executive observed (2009, interview, Geneva) “[t]he Global Fund money is increasingly predictable. GAVI and the Global Fund have predictable funding for longer than any of the bilaterals. Both GAVI and the Global Fund have been ‘learning organizations’--they have responded to the world and adapted to what countries want.”



This tension that the Global Fund faces between vertical, disease-focused interventions and horizontal system needs is nothing new (Gonzalez 1965, p. 9; Mills 2005, p. 315; Cueto, Brown and Fee 2006, p. 68; Lee 2009, p. 11; Veenstra and Whiteside 2009, p. 302). For example, the WHO in the 1950s adopted a disease focused approach through its Malaria Eradication Programme (Lee 2009, p. 11) to which the organisation committed significant resources for a period of 15 years (Lee 2009, p. 49). “Mass campaigns” as Gonzalez (1965, p. 55) described them are feasible when technology exists to combat a disease on a large scale but he also cautioned that by itself a mass campaign is not a solution arguing that “the conduct of mass campaigns and the establishment or improvement of general health services must go hand in hand for many years towards the ultimate goal of a unified health programme.” Despite Gonzalez’s point that both the vertical and the horizontal are necessary, vertical initiatives were a strategy adopted among global health actors to address the significant threat posed by HIV/AIDS. “The push to implement vertical programmes is indeed stronger where epidemics, poverty and weakened health systems coincide. The burden created by a specific disease, such as HIV/AIDS, can become so large that priority interventions will result in huge health status gains” (Veenstra and Whiteside 2009, p. 302).

Disease focused GHIs adopt their vertical strategies not only because the technology might be available to combat a disease on a large scale but also because vertical strategies are palatable to donors and more conducive to performance-based funding approaches. “Rather than countries taking ownership so that investment can be made in long-term priority setting and planning, donors focus on quick results and measurable returns through vertical programming. The focus on these quick results discourages investment in health systems and indicates the need for a country-led process of priority setting” (Sridhar and Batniji 2008, p. 1190). Gonzalez’s well-reasoned argument from 40 years ago was

expressed succinctly by one UN Executive (2009, interview, Geneva) who described the vertical versus horizontal debate in the case of the Global Fund as,

...a complete load of nonsense. It has become 'vertical' bad, 'horizontal' good and there are some functions that have to be carried out that are specific to a particular disease programme and there are some functions that need to be integrated. The whole vertical horizontal is about turf and money and not about the design of how a health service runs. If you've run a health service, you know that sometimes you need some specific facilities and sometimes you need to draw on the system.

The Global Fund's initial focus on three diseases was closely linked to its performance-based funding and its resource mobilisation and distribution efforts—in other words it was core to its innovative design. Its expansion of its mandate towards investing in health systems could be argued as necessary in order to sustain the gains it has made in the fight against the three diseases. On the other hand, by staking a claim beyond the vertical, the Global Fund risks muddying its ability satisfy donors by proving programmatic results. From the perspective of institutional innovation the Global Fund's initial vertical focus gave it a foothold to establish its leadership of global and country level public health for HIV/AIDS, tuberculosis and malaria. While its expanding scope is unlikely to eclipse the WHO's convenorship role in the near future, it could make the Global Fund's successful 'raise it, invest it, prove it' model more challenging to execute to donors' satisfaction.

The Global Fund's design, in particular its inclusive global and country level governance models, its transparency and performance-based funding and its unprecedented resource mobilisation and distribution distinguish it from traditional multilaterals and lend it its innovative character. These features of its design have underpinned its success as a

financing mechanism for MDG 6 which in turn has aided its maturation towards addressing broader health sector concerns. The next section will discuss how the Global Fund's innovative and successful model has been a disrupting force for its multilateral partners, particularly where policy leadership related to the three diseases, country level technical assistance and competition for donor government resources are concerned.

## **5. Disrupting Multilateralism – Changing Health's Policy Leadership, Technical Assistance and Resource Mobilisation Landscape**

The Global Fund has altered the multilateral landscape which has implications for its partners such as the WHO, the World Bank, UNAIDS, UNDP, the Roll Back Malaria Partnership (RBM) and the Stop TB Partnership (Stop TB) particularly where global policy leadership for the three diseases, country level technical assistance and competition for donor resources are concerned. The nature of this disruption is changing as the Global Fund matures. For example, in its early years the Global Fund's vertical disease focus and its political support from donor governments challenged the authority of disease focused health initiatives such as RBM and Stop TB. As its mandate expands and its authority grows (see Chapter 6 on the Global Fund's growing authority), the Global Fund is moving towards normative policy making, challenging the WHO's and UNAIDS' traditional policy leadership roles. This transformation is salient because as discussed in Chapter 3 it challenges the accepted state-centric basis for legitimate authority exercised by most multilaterals and more deliberately opens its own authority to the influence of wealthy and powerful states such as the United States and private actors like the Gates Foundation. The Global Fund is a form of institutional innovation but more than that it is an agent of change, disrupting the traditional multilateral order and making way for a new order to emerge.

## Policy Making Momentum and Disruption at Global Level

When the Global Fund was first created, it threatened to overtake the mandates of RBM and Stop TB. Both of these single disease organisations are secretariats within the WHO and both were created in 1998. In the case of RBM, it was founded by the WHO, UNICEF, UNDP and the World Bank to coordinate a response to malaria (Roll Back Malaria 2010, 'RBM Mandate'). Stop TB had more modest beginnings and was originally an 'initiative' until the WHO's World Health Assembly formalised it as a partnership in 2000 with two targets for 2005: to diagnose 70% of all people with infectious TB, and to cure 85% of those diagnosed (Stop TB 2010, 'About the Stop TB Partnership'). RBM and Stop TB do not have seats on the Global Fund's board like the WHO, UNAIDS and the World Bank which have non-voting rights, but they do participate on Global Fund board committees or in working groups. The relationships between the Global Fund and RBM and Stop TB have been described as strained in the early years (UN Executives 2009, interviews, Geneva). Donors were giving resources to the Global Fund ostensibly to fight three diseases, but it was largely seen as an HIV/AIDS fund. RBM and Stop TB expressed concern that not enough of the Global Fund's resources were going to their two diseases years (UN Executives 2009, interviews, Geneva). However, over the years, this perception has changed as both RBM and Stop TB have advocated to the Global Fund and worked with countries to prepare strategic and cohesive proposals (UN Executive 2009, interview, Geneva): "RBM says today that Global Fund resources are its resources. RBM advocates strongly for the Global Fund because it knows that every dollar that goes to the Global Fund comes back to ... the work ...[RBM] does." Neither organisation can compete with the Global Fund's resource mobilisation might, so their best strategy is to leverage the Global Fund's capacity and increase country success in securing malaria and tuberculosis grants.

In addition to increasing the country level financing available for malaria and tuberculosis, the Global Fund has enabled policy change related to the two diseases. This policy facilitation and implementation role is evident in the case of the introduction of the malaria drug Artemesin.<sup>13</sup> The Global Fund advocated for its use based on WHO technical guidance, countries included its introduction in their proposals to the Global Fund and the Global Fund in turn made resources available to countries to quickly implement new malaria treatment policies: “In 2003 it was clear that [Artemesin] drugs were the only ones recommended by the WHO [to treat malaria] but no country was using it...[The Global Fund’s resources meant] for manufacturers...they could start growing the plants and producing the drugs...and that’s when countries moved from chloronique and old drugs to effective drugs” (Global Fund Executive 2009, interview, Geneva). For RBM and Stop TB, the Global Fund has not only succeeded in securing resources for the two diseases, but also supported policy change at a scale that would not otherwise be possible.

The Global Fund’s leadership in HIV/AIDS has been less straightforward (see Chapter 5 for a detailed discussion on the Global Fund’s influence on Malawi’s HIV/AIDS prevention strategy). Undeniably the Global Fund has made resources available to fight the virus that have, in a relatively short time period, made possible the declaration by UNAIDS’ Executive Director in 2010 that “[w]e have halted and begun to reverse the epidemic. Fewer people are becoming infected with HIV and fewer people are dying from AIDS” (UNAIDS 2010d, p. 5). However, the magnitude of these resources, particularly their scale at country level (see Chapter 4 for a discussion on the Global Fund and its aid relationship in Malawi) has lent the Global Fund considerable policy influence, described by one UN Executive (2010, interview, Geneva) as,

...driving the normative agenda [through criteria built into Global Fund applications]...They can advance [for example policies related to] gender more

proactively than...[our organisation]. We don't have the carrot of money. The danger is that the Global Fund application becomes the driving force of what is in the national response.

The Global Fund may not be a traditional policy maker in the way that the WHO and UNAIDS are able to do with their convenorship, technical expertise and research capabilities. But the Global Fund's aid relationship does give it considerable influence and normative policy making muscle.

Although the Global Fund has the 'carrot of money', its resources are limited relative to the scale of need. For example, in 2009 the WHO introduced new guidelines for anti-retrovirals which recommended that those infected be eligible for treatment sooner and, to reduce debilitating side effects of the first line therapies used in most countries, that more expensive second line drugs be used (WHO 2009, 'New HIV Recommendations'). The WHO's new policy guidelines effectively increased the demand for and cost of treatment. Unlike the Artemesin example, the Global Fund was not in a position to enable wholesale country-level policy change. The Global Fund (2010j, 'Report of the Executive Director') reported in 2010 that "[g]lobal ART [anti-retroviral therapy] coverage was estimated at 36 per cent at the end of 2009 based on the WHO 2010 treatment guidelines [which include prevention of mother to child transmission or PMTCT guidance]; if based on the 2006 guidelines, global coverage would have stood at 52 per cent." Strictly speaking the Global Fund was not intended to be a policy-maker but a "new, innovative financing instrument...;[nevertheless,] over the years we have seen the Global Fund evolve as a financing institution and also that with its growing size a larger role in the global health discussion has become unavoidable. So it was not by design but by size, by weight. So therefore today, the Global Fund plays quite a leading role in these discussions" (Global

Fund Executive 2009, interview, Geneva). The momentum of the Global Fund's policy role towards that of policy-maker has challenged the traditional health policy-makers including the WHO and UNAIDS. One UN Executive (2010, interview, Geneva) observed, "[a]t global level, there is regular tension in terms of who should be doing what. The Global Fund has to keep itself relevant to donors. From the UN side of things if it didn't exist, it would have to be invented. There are alternatives to the Global Fund, like the World Bank, and they know this." The Global Fund's policy-making is gaining momentum as it matures, disrupting the division of labour among traditional health policy makers.

#### The 'Unfunded Mandate' and Disruption at Country Level

The independence of the Global Fund's country level governance model and lack of a country office presence can be seen as promoting 'country ownership' and streaming Global Fund resources towards a response to the three diseases and away from overhead and personnel costs. It is also a disruptive force. One of its side effects is a flourishing 'cottage industry' for technical assistance provided by organisations like UNAIDS and UNDP in order for countries to prepare successful grant applications and evaluate and report their results. Another side effect is the challenge of delineating country level roles when an organisation like the World Bank also has an HIV/AIDS financing role.

UNAIDS is one organisation which has stepped in to provide technical assistance to Global Fund applicants, which it refers to as its 'unfunded mandate' (UNAIDS 2005a, p. 3). The Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors called on the UNAIDS Secretariat to lead a process with UNAIDS' Cosponsors to clarify and cost a UN system division of labour for technical support to assist countries to implement their annual priority AIDS action plans (UNAIDS

2005a, p. 3). The result included a clarification on who does what, and also processes and procedures for managing the division of labour at country level. However, the complexity of the relationship between UNAIDS and the Global Fund goes far beyond UNAIDS' country level role:

UNAIDS has had to rethink its role. ... There is a changed environment, including the Global Fund, PEPFAR—it's more complex. UNAIDS [has to consider] its comparative advantage... [It's] a little schizophrenic. UNAIDS supports countries in applying to the Global Fund and in implementation. At the same time it helps with eligibility criteria and it's on the [Global Fund's] board... it's an ongoing evolution (UN Executive 2010, interview, Geneva).

UNAIDS' 'unfunded mandate' is a double edged sword—UNAIDS must find the resources to provide technical assistance to countries for Global Fund applications, but it is also in UNAIDS' interests if countries, particularly HIV/AIDS endemic countries with little capacity, can be successful in securing Global Fund resources.

Similarly UNDP provides technical assistance for the Global Fund and it also fulfils a 'Principal Recipient of last resort' function. UNDP like the World Bank has promoted a multi-sectoral approach to HIV/AIDS. UNDP adopted this strategy in the 1980s when it recognised the socioeconomic dynamics of HIV/AIDS and that its long term implications required more than a traditional public health intervention approach (Harman 2009, p. 166). UNDP as a cosponsor of UNAIDS is responsible for activities related to “development planning and mainstreaming; governance of AIDS responses; and law, human rights and gender, including sexual minorities” (UNDP 2008, p. 3). UNDP's technical assistance reflects its mandate. For example, it might work with a CCM to develop and support a gender transformative programme which can be critical to effective



interventions for HIV/AIDS. As Lisk (2010, p. 97) observed, “[h]alting and reversing the spread of HIV/AIDS...is perceived by the UNDP as requiring an operational framework that links the causes and consequences of the epidemic to action against poverty and a range of development concerns...” UNDP can be a significant contributor to the success of Global Fund programmes at country level. Through its ‘unfunded mandate’ it places the HIV/AIDS epidemic, and therefore strategies to address it, in a larger socio-economic context.

At country level, the World Bank has a different kind of technical assistance challenge from UNAIDS or UNDP. The World Bank created its Multi-Country HIV/AIDS Program in 2000. The Multi-Country HIV/AIDS Program provides financing and technical assistance for low- and middle-income countries with a strategic plan to fight HIV/AIDS which must include the involvement of non-state actors (Lisk 2010, p. 77). In 2005 the World Bank and the Global Fund commissioned a review of their respective efforts “intended to help the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank build a stronger and more complementary partnership that will enhance the international community’s ability to achieve its ambitious HIV/AIDS goals” (Shakow 2006, p. 3). Among the review’s thematic findings were that the Global Fund needed to,

...give much greater strategic and operational precision to its financing role... Its main focus in this regard should be on financing directly the prevention and treatment of the three diseases. In differentiation from this, bilateral and multilateral donors in the UNAIDS family, including the World Bank, should provide more support for policy dialogue, analytic work, project preparation and implementation at the country level (Shakow 2006, p. 6).

The review also indicated that the World Bank should focus on its,

systemic health sector capacity building.... [The Bank has] the ability to link the health sector to broader macroeconomic and budgetary issues in each country. Similarly, the Bank should help governments to be more strategic and selective in setting priorities for its AIDS and health activities, encouraging countries to use their limited capacities to implement activities that will have the greatest impact on the epidemic (Shakow 2006, p. 6).

Maintaining the clarity of these delineations--the Global Fund providing financing and the World Bank providing health sector capacity building—has not taken hold as the Global Fund's expansion into health systems strengthening and National Strategy Approaches reveals.

The 'unfunded mandate' for technical assistance necessarily adopted by partners such as UNAIDS and UNDP compensates for the Global Fund's independent country-level governance model and its lack of country infrastructure. A number of remedies for this dilemma have been put forward including the U.S. Government's Grant Management Solutions which it funds by deducting 5% from its Global Fund contribution (The Global Fund 2010a, 'Technical Assistance'). The Global Fund's claim that its lack of country infrastructure is efficient belies the reality of the extent to which other organisations fill the technical assistance void. As the Global Fund matures and its mandate expands from its initial vertical focus on three diseases, the extent of the Global Fund's disrupting effects on its country-level partners will intensify. The demand for technical assistance is unlikely to decline and the negotiation of who does what and who funds what will continue.

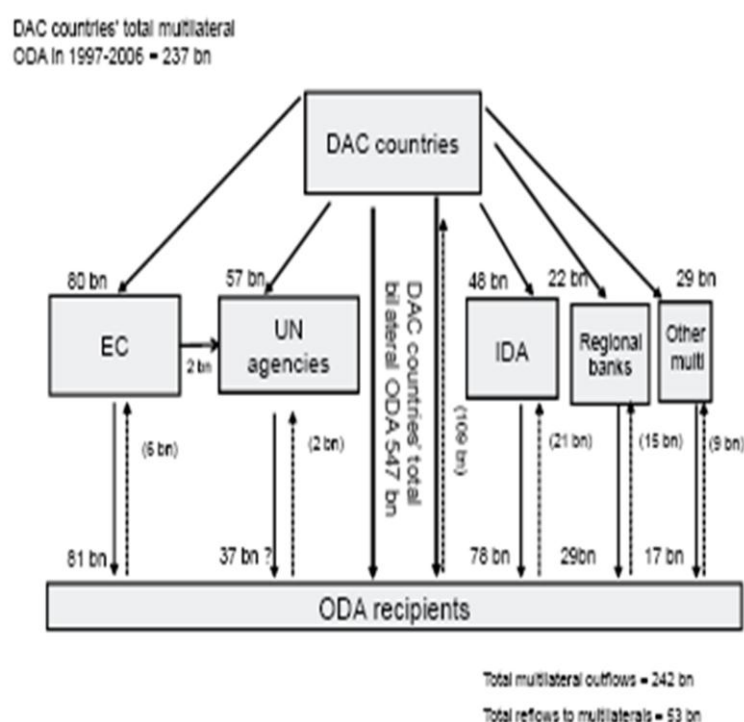
Competition for Health Resources: Disruption beyond the Health Sector

Overall, development assistance for health has increased more than four-fold between 1990 and 2007 (Ravishankar et al 2009, p. 2113). While this is a good news story for recipient countries and their ability to respond to the MDGs that relate to health, it raises the resource mobilisation bar, particularly for UN organisations that traditionally have not faced much direct sector based competition during replenishment cycles or donor conferences. It also brings the notion of competition among health multilaterals for donor resources to the fore.

**Figure 2: 2008 DAC Report on Multilateral Aid (OECD 2009, p. 27)**

**Figure 2.6. ODA gross disbursements (core contributions) and reflows 1997-2006, cumulative (excluding debt relief)**

Constant 2006 USD billion



Source: DAC Aggregate Statistics.

Note: The EC both receives and provides multilateral aid. Core contributions from the EC to other multilaterals 1997-2006 were: UN – USD 2.2 bn (shown in the figure), World Bank Group – USD 2.2 bn (IDA 1.7 bn, IBRD 0.5), regional development banks – USD 18 million, and other agencies – USD 605 million.

Unravelling aid flows is a complex and inexact undertaking, particularly tracking aid from donor governments to multilaterals and then from the multilaterals to sectors such as health or to individual countries. At a macro level, the OECD (2009, p. 12) estimates that in 2006 a total of US\$43 bn in Official Development Assistance (ODA) was routed through the multilateral system. Figure 2 (OECD 2009, p. 27) shows direct and indirect bilateral and multilateral aid flows from OECD Development Assistance Committee (DAC) countries between 1997 and 2006. In principle, the Global Fund ‘competes’ among other multilaterals for donor government aid which comprises 96% of the US\$21 bn in total resources it raised before its most recent replenishment cycle (The Global Fund 2010f, ‘Pledges and Contributions’). Forman and Segaar (2006, p. 218) assert that GHIs like the Global Fund divert resources away from other health multilateral organisations such as the WHO which relies primarily on voluntary rather than assessed contributions:

Partnerships focusing on a single illness, for example, may divert resources from overall World Health Organization (WHO) efforts to develop sustainable national primary health care systems. Arrangements involving private sector provision of cheap or free goods and services also require public funds and hence can compete with UN agencies’ efforts to obtain funds from the same donor sources.

In interviews, several Global Health Executives played down the issue of competition providing three reasons. In some cases the scale of funds raised by an organisation was significantly less than the Global Fund and therefore their resource mobilisation was in a ‘different league’. Others felt that the reputation and legitimacy of their organisations with donors meant that if they made a good case for resources they were very likely to be successful and therefore they were not duly affected by the Global Fund’s success. Perhaps the most positive point of view was that the Global Fund in fact helped other global health organisations by making a successful case for the increased need for health

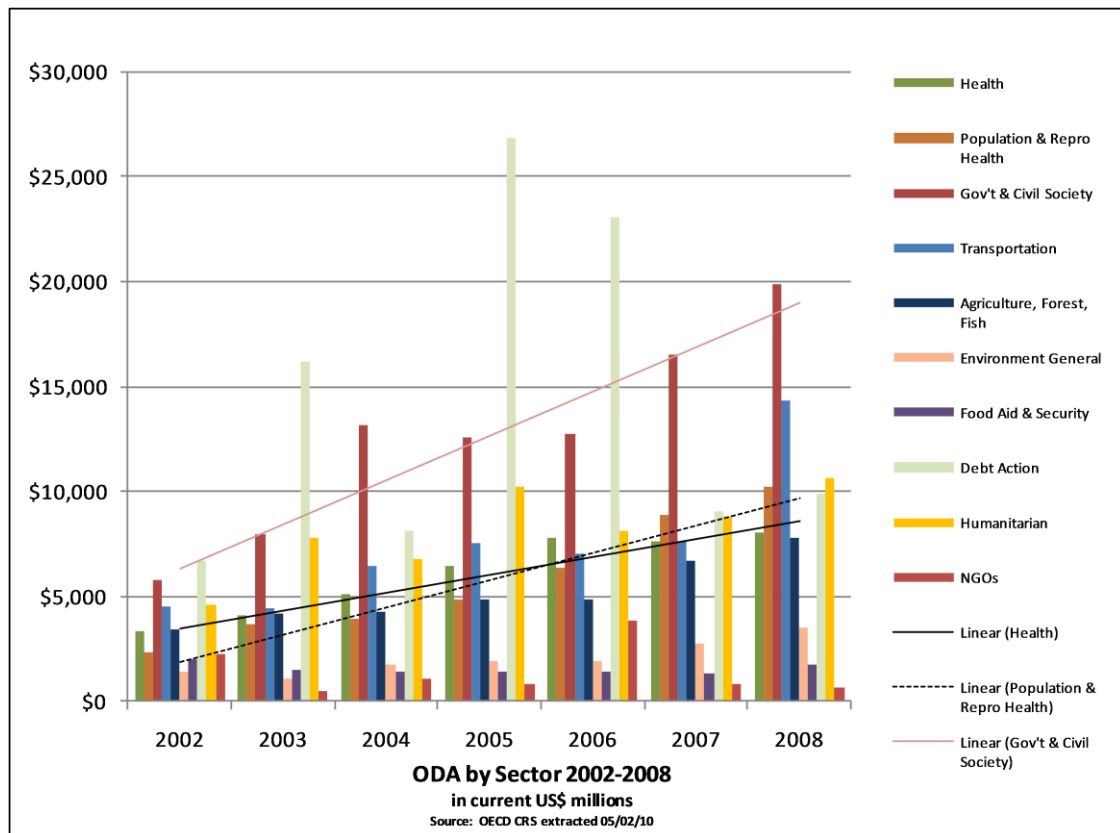
funding overall, not just to three diseases or to the Global Fund exclusively (UN Executives and Global Fund Executives 2009, interviews, Geneva). One GAVI Executive (2010, interview, Geneva) expressed the view that competition among health multilaterals for donor resources was not the issue; rather, the challenge was demonstrating coordination and the effective use of those resources:

Donors want to know that there are synergies between the organisations they are funding. They want to fund a range of instruments and see that their investments are complementary. You don't want to provide a child ART [anti-retroviral therapy] and then have that child die from a preventable illness [which could have been treated].

Although health multilaterals do compete to some extent for donor funds, concern over competition was not evident from interviews conducted for this thesis. Rather, the issue of coordination among institutions to demonstrate their complementarity was seen as a bigger challenge.

The health envelope relative to other sectors is shown in Figure 3. It reveals that aid for health (which includes aid to fight infectious diseases such as malaria, polio and measles) has increased at a slower rate than aid for population and reproductive health (which includes aid to fight HIV/AIDS and tuberculosis related to HIV/AIDS). In comparison, it also shows that aid for other sectors such as governance and civil society, which includes aid to strengthen the rule of law, democracy and governance as well as for conflict, peace and security has increased more rapidly than that for population and reproductive health. Funding for health has increased dramatically relative to its historic levels, but sustaining this growth will require health multilaterals to make a compelling case relative to the pressures that donor governments face across many demands.

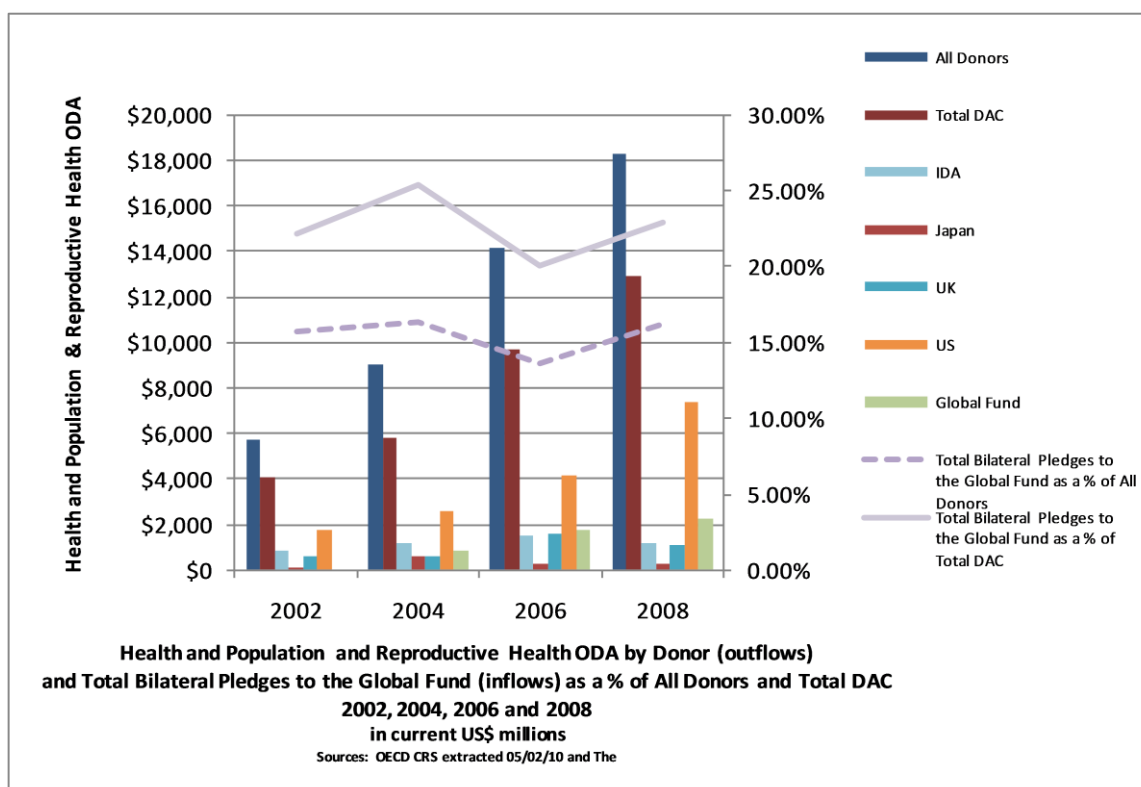
**Figure 3: ODA by Select Sectors 2002-08**



The scale of the Global Fund’s resource mobilisation is evident in Figure 4. When comparing it to total health and population and reproductive health ODA, bilateral pledges to the Global Fund peak in 2008 at just under 23% of total DAC ODA for the two health areas. The Global Fund’s ODA (meaning the funding it provides) for health and population and reproductive health is greater than that of the the United Kingdom. It is not surprising that one observer noted that given the size of the Global Fund’s ‘take’ of health ODA, it does not compete with multilateral health organisations for donor government funds as much as it should concern itself with other sectors like peace and security, climate and food security which have the potential to attract donor interests away from health and grow their share of overall ODA (Global Fund Executive 2009, interview, Geneva). The assertion that the Global Fund competes with other multilateral health organisations for

donor resources is true but may be missing the larger picture which is that given the scale of the ODA the Global Fund commands, its real ability to increase its resources likely lies outside DAC, and outside of the health envelope if it is to sustain its success in the face of emerging concerns like environment and food security.

**Figure 4: Health and Population and Reproductive Health ODA by Donor and Total Bilateral Global Pledges as a %**



One strategy employed by the Global Fund to sustain its resource mobilisation efforts with donors is to look to civil society for its ability to exert political pressure and to advocate for its own and the Global Fund's common interests. As Bartsch (2007a, p. 170) observed:

The GF [Global Fund] must mobilize enough resources to ensure that the activities supported by its grants are sustainable in the long run and that treatment programmes, in particular, will be continued as long as they are needed. This requires strong advocacy efforts by the GF itself and its partners (especially CSOs)

to motivate donors to maintain or restore their commitments towards the GF and the exploration of new avenues of funding in the future.

Beyond advocacy, CSOs and NGOs have a very strong self-interest in Global Fund resources as they are also often direct beneficiaries at country level where they may be a Principal Recipient or sub-recipient of funds and involved in implementation. As one Global Fund Executive (2009, interview, Geneva) noted "...If you have the choice to give money to the World Bank or the Asian Development Bank or the Global Fund and you know that if you give money to the Global Fund the NGOs will all say great and if you don't do it, you might ...have an article in the paper saying you are putting millions of lives in danger, then you might think it's a good idea to support the Global Fund whether you like it or not." While the advocacy of CSOs and NGOs does not resolve questions of sustainability, it certainly acts as insurance for the 'morally binding' nature of donor commitments to the Global Fund.

Despite the extent of the Global Fund's resource mobilisation success, demand among recipients shows no signs of abating. In 2007 the estimated global funding gap for HIV/AIDS alone was US\$8.1 bn (Lisk 2010, p. 111) and this was before the first wave of the global financial crisis that took hold in 2008 and 2009. In April 2009 the Global Fund (2009b, 'Donors Assess Global Fund Resource Needs') estimated its funding gap at US\$ 4 bn against its projected 2010 commitments. In response, a Global Fund working group proposed seeking budget reductions from applicants and 'efficiencies' of 10% and 25% in funding tranches. Further in 2010, the Global Fund failed to meet its minimum threshold of US\$13 bn in its third donor replenishment cycle for 2011-2013, achieving pledges of US\$11.7 bn (The Global Fund 2010g, 'Press Release: Donors commit US\$11.7 billion'). Among the many challenges of raising funds when many donor governments face



significant spending constraints is the sustainability of their commitment to HIV/AIDS, or what one UN Executive (2010, interview, Geneva) called the ‘treatment mortgage’:

The big funders are trying to transfer the obligation to whoever they can find.

PEPFAR wants to transfer it to the Global Fund and the Global Fund wants to transfer it to countries. It’s the hot potato of the AIDS response...The world can’t afford to let the model die. It’s stuck with chronic treatment and it can’t back away.

Achieving supply and addressing demand for resources for AIDS treatment in particular is no easy task. It is a long-term economic, social and moral commitment by donors and recipient countries and the Global Fund’s role is to make a compelling case. As described earlier in this chapter, the view that competition for funds is less of a concern than demonstrating coordination does not seem to align with the realities of growing demands of the pandemic response and the long term nature of the treatment mortgage. It does however support at least in the near term an increasing reliance on and influence of the United States (see Chapter 3 for further discussion). Nevertheless, the pressures faced by the Global Fund suggest that sustainability will also involve moving beyond relying on traditional resource mobilisation from a few donor governments and require it to compete successfully for health resources against other sectors and develop non-DAC and private sector sources.

The rapid rise of the Global Fund as a global health leader has disrupted the multilateral landscape in terms of global health policy leadership for the three diseases, country level technical assistance and effective resource mobilisation. Other international institutions working in global health and the three diseases--the WHO, UNAIDS, the World Bank, UNDP, RBM and Stop TB continue to adjust their strategies and reassert their mandates.

The Global Fund's decisions to support health systems strengthening and fund National Strategy Approaches signals that it is maturing from a start up financing mechanism with a vertical, disease focus to an international health institution with scope and influence beyond its initial mandate. The Global Fund is gaining momentum towards policy-making, moving towards sector leadership at country level and facing continued pressure to mobilise resources to address the 'treatment mortgage'. Within the multilateral order related to health, the Global Fund is more than an agent of change, it has become a disruptive force that is altering the multilateral order of 'old' where health is concerned and influencing the new order that is taking shape.

## **6. Conclusion**

The Global Fund is a form of institutional innovation that has disrupted traditional multilateralism where health is concerned; however a new order has yet to emerge. A confluence of events laid the foundation for change from which the Global Fund was created. These included a political and discursive case for change and the availability of new sources of funds from donor governments and private actors, predominantly from the Gates Foundation, to address HIV/AIDS, tuberculosis and malaria. These events together with the UN's desire to embrace private actors and the neo-liberal virtues attributed to a 'private ethos' paved the way for the Global Fund's unique design and its hybrid public/private character.

The Global Fund's design including its inclusive governance, its transparency and performance-based funding approach and the scale of its resource mobilisation and distribution are a form of institutional innovation. As the Global Fund matures, it is expanding beyond its modest beginnings as a financing mechanism for three diseases towards broader involvement in and influence on the health sector at global and country

levels. Its form of institutional innovation at once distinguishes it from traditional multilaterals like the WHO, and provides a platform for its growth. As a result the Global Fund has become a disruptive force.

The Global Fund has challenged the leadership and division of labour among multilaterals and international health institutions including the WHO, UNAIDS, UNDP, the World Bank, Roll Back Malaria and Stop TB. It is gaining momentum beyond policy implementer towards policy maker at global level. At country level, the independence of its governance model and its own lack of country infrastructure has created an ‘unfunded mandate’ for its partners and its scale and scope will continue to challenge the arrangements of who does what. The Global Fund’s resource mobilisation success goes beyond intensifying competition among multilaterals for donor resources. For the Global Fund to sustain its efforts it will need to compete successfully beyond health actors and the pressures it faces in this regard are unlikely to diminish. (Chapter 3 will explore the nature of this disruption further relative to the legitimate authority of states central to most multilateral systems of governance). In sum, the Global Fund is a form of institutional innovation which has disrupted the traditional multilateral order related to health. It has become a ‘game changer’ shaping the new order that is emerging from Kirton and Cooper’s “Westphalian order of old.”

## **Chapter 3 - The Global Fund: New Sources of Legitimacy and the Accountability Link**

### **1. Introduction**

To anticipate the prospects for global governance in the decades ahead is to discern powerful tensions, profound contradictions, and perplexing paradoxes. It is to search for order in disorder, for coherence in contradiction, and for continuity in change. It is to confront processes that mask both growth and decay. It is to look for authorities that are obscure, boundaries that are in flux, and systems of rule that are emergent. And it is to experience hope embedded in despair (Rosenau 1995, p. 13).

The previous chapter made a case for the Global Fund as a form of institutional innovation within multilateralism, one that is a disruptive force shaping an emerging order. This chapter builds on the notion of institutional innovation examining the Global Fund's legitimacy and accountability as examples of how global health governance is evolving. The first section explores broad themes arising from the literature on legitimacy and how traditional bases are challenged by models of government and governance which do not rely solely on the relationship between a democratic state and its citizens. By contrast it examines how traditional multilaterals derive legitimacy through a governance model which relies on the representation of states. It refers to the three features of the Global Fund's institutionally innovative design--its inclusive governance, its transparency and performance-based funding and its resource mobilisation and distribution--making the case that not only do these features distinguish the Global Fund from traditional multilateral institutions but they also provide it with new sources of legitimacy as well as the capacity to make claims (Barker 2000, p. 9).

The first section of this Chapter argues that despite their input-oriented appearance, Global Fund's sources of legitimacy are largely focused on outcomes and conferred by wealthy and powerful states. The second section of this chapter explores accountability, making the case for its normative and rational aspects analogous to those of legitimacy. It links the Global Fund's outcome focused legitimacy with its hierarchical accountability model which ultimately holds the Global Fund and its grant recipients accountable to donor governments. It argues that the Global Fund has an accountability gap which lies in its inability to reconcile its accountability to its 'publics' and the people whose lives it affects which is in part obscured by its legitimating claims, revealing the "powerful tensions, profound contradictions, and perplexing paradoxes" (Rosenau 1995, p. 13) at play in an emerging global health governance order. The Global Fund's accountability gap is taken up in greater depth in subsequent chapters including Chapter 6 which argues that the 'publicness' conferred on the Global Fund's authority and its rapid growth at both global and country levels not only exacerbates its accountability gap but also obscures it, evidence that where the Global Fund is concerned "boundaries are in flux, and systems of rule are emergent" (Rosenau 1995, p. 13).

## **2. The Nature of Legitimacy and the Challenge of Legitimate Governance**

Legitimacy helps to explain who makes rules and on whose behalf and how this authority arises in ways other than by coercion. According to Hurd (1999, p. 401), "...the character of power changes when it is exercised within a structure of legitimate relations, and the two concepts of power and legitimacy come together in the idea of "authority." This discussion will not attempt uncover the vast literature on legitimacy and its many tributaries (see for example Barker 2000, p. 8, Beetham and Lord 1998, p. 16; Bernstein 2004, p. 142), but will locate the discussion relative to those aspects that are most useful in understanding the unique nature of the Global Fund's legitimacy, its relationship to

accountability and later, in Chapter 6, its implications for the Global Fund's exercise of authority which has seen a rapid rise both at global and country levels. The discussion introduces select perspectives on the nature of legitimacy, its qualities, its necessary conditions and its self-generating capacity. A final comment will be made on the challenge of ascribing and deriving legitimacy outside of the realist-positivist focus on the authority of the nation state and state-governed global institutions. As Beetham and Lord (1998, p. 15) note, despite a robust scholarly history, legitimacy and its concepts remain varied and what emerges is a picture of complexity and challenge.

Weber (1922, p. 215) describes the qualities of legitimacy as, i) rational, "resting on a belief in the legality of enacted rules"; ii) traditional, "resting on an established belief in the sanctity of immemorial traditions"; and iii) charismatic "resting on devotion to the exceptional sanctity, heroism or exemplary character of an individual person." Like Weber, contemporary scholars describe legitimacy as being derived through rule based systems, in particular those associated with rule of law and democratic process (see for example Green 1988-9, p. 796; Tyler and Darley 2000, p. 724; Slaughter 2004a p. 178; Bernstein 2004-5, p. 154), and through beliefs that those rules are valid and desirable (Nanz and Steffek 2004, p. 318; Ruggie 2004, p. 504; Zürn 2004, p. 261; Bartsch 2007b, p. 5). Legitimacy is derived both rationally and normatively, or as Barker (2001, p. 8) suggests, through some combination of what is and what ought.

Legitimacy is also normatively relational. According to Hurd (1999, p. 381) the idea of legitimacy is inherent in the "...belief by an actor that a rule or institution ought to be obeyed. It is a subjective quality, relational between actor and institution, and defined by the actor's perception of the institution." Beetham and Lord (1998, p. 16) separate out the relational aspects of legitimacy which they associate with liberal democracy by

distinguishing between the authority accorded sovereignty and the role of government to protect basic rights, the performance of political orders, and the “public recognition or affirmation of authority by those qualified to give it.” An underlying idea here is that legitimacy helps constitute what Raz describes as authority ‘over’ and authority ‘given’:

One can have authority over some people and not over others. If citizens have no general obligation to obey the law, then the state has no authority over them merely by virtue of their being citizens. It does not follow, however, that no one is subject to the authority of the state. The state can be given authority by some or all of its citizens, and it has authority over those who gave it authority (Raz 1981, p. 188).

Grafstein (1981, p. 463) points out the tautological problem with this Weberian dynamic because it is difficult “...to distinguish the case where the claim to legitimacy is made and there is political obedience from the case where there is obedience because of the claim to legitimacy.” Although Grafstein (1981, p. 463) goes on to question the need for the concept of legitimacy at all, Bernstein (2004, p. 142) makes a case for its renewed importance in order to describe authority that arises from new institutional arrangements outside of traditional rules of democratic process associated with the nation state.

Focusing on legitimacy’s qualities and its nature reduces it to a ‘thing’. However, Barker (2000, p. 9) argues that it is also a self-referential and self-generating act:

Governing is an activity legitimated in a myriad ways, and the absence of democratic legitimation will throw into relief how much legitimation is by government and *for* government...where the legitimating activities of government...once the justifying ends ... are more contested and more varied.”

If Suchman’s (1995, p. 574) sociological description of legitimacy is accepted as “a generalized perception or assumption that the actions of an entity are desirable, proper, or

appropriate within some socially constructed system of norms, values, beliefs, and assumptions”, then it follows that perceptions or assumptions can be derived through claims. When the sphere in which legitimation occurs is chaotic, where “[a]genda setting is more contested, externalized beyond the nation-state, and open to the input and disruption of a variety of political agents” (Stone 2008, p. 26), then claims have a place and even a payoff. In Barker’s (2000, p. 10) view legitimation is not only a characteristic of government (here government could be more broadly read as “authority”), but also shapes its structure and ethos.

The allusion to a chaotic sphere suggests a struggle for location when legitimacy arises outside of the confines of the rules and beliefs associated with the nation state. There is a large and growing literature on legitimacy and the ‘public sphere’ only some of which will be touched on here. First of all, the definitions for what constitutes a public sphere are largely conceptual (see Ruggie 2004, p. 519; Nanz and Steffek 2004, p. 315; Castells 2008, p. 78). However, if legitimacy is the “acceptance and justification of shared rule by a community” (Bernstein 2004, p. 142) and both the rule maker and the community are likely to exist beyond the borders of a nation state and outside democratic processes, then traditional assumptions about who makes rules and on whose behalf are challenged.

In taking up the challenge, scholars differ in their tolerance for the dislocation of legitimacy from the realist-positivist focus on the authority of the nation state and state-governed global institutions. For example, in considering the legitimacy of the European Union, Beetham and Lord (1998, pp. 17-18) assert that it is acquiring its own, unique normative validity one which is closely associated with its impact on citizens, its jurisdiction and its effects on the legitimacy of its nation states. Zürn and Ruggie more readily depart from “Westphalian state-centrism” (Zürn 2004, p. 277) , recognising the



existence of a public domain as “the arena in which expectations regarding legitimate social purposes, including the respective roles of different social sectors and actors, are articulated, contested, and take shape as social facts” (Ruggie 2004, p. 504). Taking another step, there is a substantial discourse on democratic legitimation which concerns itself with the deliberative processes that occur among the actors in Ruggie’s public domain or public sphere. Much is made of civil society in this regard, where “...organized civil society has a high potential to act as a ‘transmission belt’ between deliberative processes within international organizations and emerging transnational public spheres” (Nanz and Steffek 2004, p. 323). Held and McGrew (2003, p. 186) describe this dislocation, or perhaps relocation, of legitimacy outside of the system of states as a “heterarchy—a divided authority system—with states seeking to share the tasks of governance with a complex array of institutions in public and private, transnational, regional and global domains, the emergence of overlapping “communities of fate.””

### Legitimate Governance and Traditional Multilaterals

The legitimacy associated with the governance of traditional multilaterals retains its association with the authority of the nation state but not wholly. This section highlights the debate on what is broadly termed a democratic deficit of multilaterals or put another way, whether the IFIs in particular can be said to be sufficiently ‘by the people’ (Scharpf 1999, p. 2). As Bernstein (2004, p. 142) observes, “[w]hether or not legitimacy was always necessary for international stability and patterned behaviour, the extended scope and reach of contemporary ‘global governance’ has made that need much more visible.”

Scharpf (1999, p. 2) describes legitimacy as comprised of “input-oriented authenticity (*government by the people*) and output-oriented effectiveness (*government for the people*)”. Through his input- and output-oriented dimensions, Scharpf distinguishes

between those sources of legitimacy which are reliant on democratic processes and those which are reliant on demonstrating outcomes. Further, Scharpf (1999, p. 6) maintains that the former--*by the people*--derives legitimacy from the “authentic preferences of a community” where there is an established collective identity like that found in national democracies. The latter--*for the people*—“promotes the common welfare of a constituency”, where there may be several coexisting identities at play. Legitimacy then for Scharpf is conferred through the ways that constituents are represented to their organisations and what actions organisations take in their constituents’ interests.

The model for legitimate governance among multilaterals resembles Scharpf’s concept of input-oriented legitimacy which also has what Bartsch (2007b, p. 5) describes as a “normative validity.” Put simply, this normative validity begins with accepting that nation states through democratic processes reflect the ‘will of the people’ and then confer this representative legitimacy on the multilateral organisations whose memberships they comprise. According to Bartsch (2007b, p. 5), “[i]n the context of the nation state the normative validity of the order is established through delegative processes via elections, which makes states legitimate actors at global level, too. This is – to a lesser degree – also the case for International Organizations, which are comprised of nation states and can thus derive legitimacy from their members.” Thus, similar to Beetham and Lord’s (1998, pp. 17-18) analysis of the legitimacy acquired by the European Union, Bartsch views the legitimacy of the state-centred model of governance of traditional multilateral organisations as having a fundamental rational, or process based input-orientation which is accompanied by a “normative validity”; or, put another way, the legitimacy of this governance model is it conferred through what Keohane (2006, p. 11) calls the “doctrine of sovereignty.”

As Bartsch suggests, the ‘doctrine of sovereignty’ is not unassailable. Much has been made of the ‘democratic deficit’ of multilateral organisations which is said to arise from several causes: nation state members of these organisations may not be democratically governed themselves; the governance structure of the institution--as is the case with the World Bank and the IMF--may not have a one state, one vote system rendering some states more powerful than others; and, the distance between citizens or ‘the people’ of member states and the governance of multilateral organisations is large--decision making by these organisations can “exclude large numbers of people...on a global basis” (Keohane 2006, p. 14, also see Nye 2001, p. 3; Nanz and Steffek 2004, p. 315).

In his discussion of what he terms the democratic deficit of multilateral organisations, Keohane (2006, p. 3) argues that “[d]emands for multilateral organizations to become more accountable to “civil society” rather than simply to states have proliferated. Insofar as these views become widespread, the sociological legitimacy of statism will decline and multilateral organizations will need to find new bases for their claims of legitimacy in the 21st century.” Similarly Ruggie (2004, p. 522) notes a dislocation from statism when he describes “the progressive arrival...of a distinctive public domain—thinner, more partial, and more fragile than its domestic counterpart...but existing and taking root apart from the sphere of interstate relations.” The reliance of multilateral institutions on the ‘doctrine of sovereignty’ as a source of input-oriented legitimacy is open to challenge exactly because it fails the test of being sufficiently representative or truly ‘by the people’.

Not all scholars are convinced by arguments that a ‘democratic deficit’ detracts from the legitimacy of governance of multilateral organisations. Moravcsik (2004, pp. 346-7) denies the importance of the ‘democratic deficit’ to global level governance mechanisms, making a plea for a less utopian and more practical realisation of democratic practice:

...social complexity, political uncertainty, and underlying differentials in social power – give rise to widespread, consistent, normatively justified exceptions to direct democratic participation in decision-making. In each of these cases, under many circumstances more insulated and delegated authority of global governance structures might be thought of as more ‘representative’ of citizen concerns precisely because they are less directly ‘democratic’.

Börzal and Risse (2002, p. 18) in their discussion of the ‘democratic deficit’ of global public private partnerships come down on the side of ‘it depends’, arguing that an institution which demonstrates what they describe as inclusive governance arrangements and accountable and transparent governance practices may not experience a deficit in democracy or legitimacy. Whether a ‘democratic deficit’ exists and whether it affects the legitimacy of multilateral organisations remains contentious. There is, however, more to the legitimacy of the governance models of multilateral organisations than the processes and mechanisms of representation and debates on the normative strengths and weaknesses of a state-centred approach.

Multilateral organisations can also create legitimacy through what Bartsch and other scholars describe (after Weber) as fostering a “belief in [their] legitimacy” (Bartsch 2007b, p. 5 and Hurd 1999, p. 381; also see Zürn 2004, p. 261; Buchanan and Keohane 2006, p. 407). This subjectiveness is similar to Barker’s (2000, p. 9) notion of the act of legitimising or making claims. Where input-oriented legitimacy can trace representation from citizens to governments to multilateral organisations, output-oriented legitimacy must contend with its “thin” collective identity and the “multiple, nested or overlapping” (Scharpf 1999, p. 11) concerns of those who participate in global level governance. Legitimizing can effect a cohesiveness where output-oriented legitimacy arises from “its

capacity to solve problems requiring collective solutions, because they could not be solved through individual action, through market exchanges or through voluntary cooperation in civil society.” In other words, legitimating and output-oriented legitimacy are closely linked where the claim to outcomes is a basis through which to bind together the concerns of a ‘thin’ global polity. It also leaves bare the question of whose beliefs or perceptions of legitimacy are of concern--legitimacy in whose eyes?

The three sections that follow will explore the Global Fund’s distinct design as sources of legitimacy: its inclusive global and country level governance models, its transparency and performance-based funding modus-operandi and the scale of its resource mobilisation and distribution. These sources of legitimacy are an intrinsic part of the Global Fund’s initial mandate as a financing mechanism to address MDG 6 (the Global Fund’s design was described earlier in Chapter 2). Its inclusive governance and its transparency and performance-based funding modus operandi are intrinsically linked to its capability to mobilise the funds it requires from donor governments and provide assurance that these funds are distributed efficiently and effectively. The Global Fund’s efforts to reflect the interests of its many constituencies may not be the input-oriented legitimacy that it first appears. The need to satisfy donor governments puts strong pressure on the Global Fund to foster a belief in its performance lending its legitimacy an output-oriented character. Although its governance model is distinct from that of traditional multilaterals, the Global Fund’s legitimacy is nevertheless conferred predominantly by and is therefore reliant on powerful donor governments. Despite the inclusion of non-state actors in the Global Fund’s governance at global and country levels, legitimacy in the eyes of donor governments takes precedence.

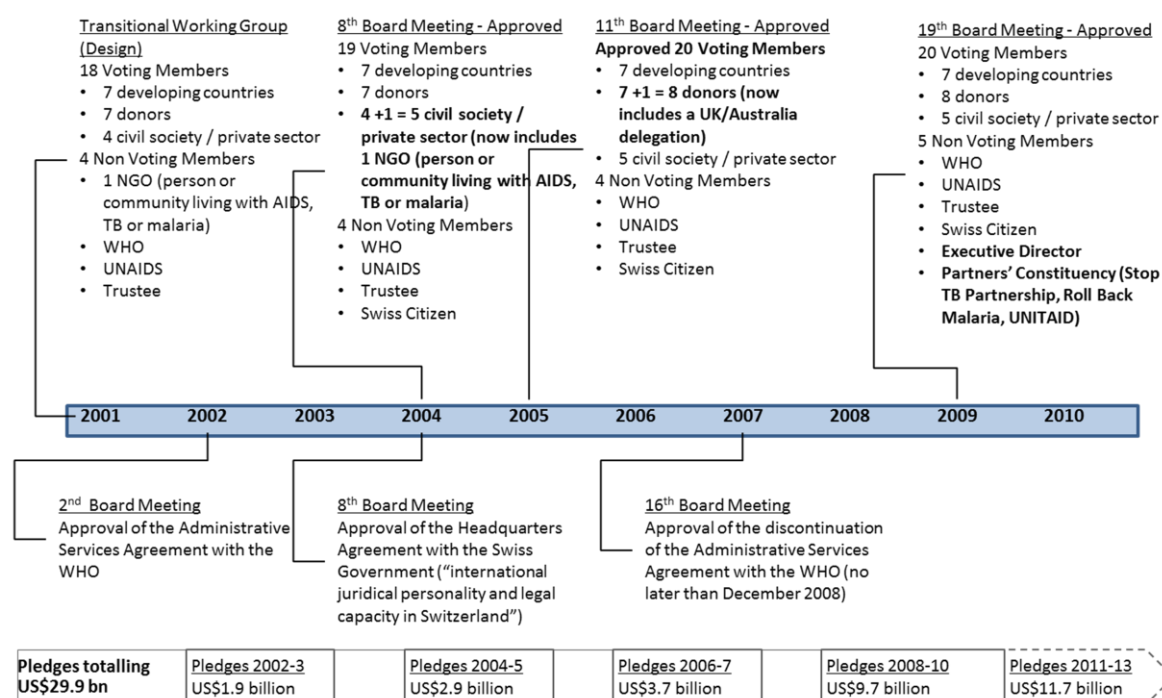
#### The Global Fund, Legitimacy and Inclusive Governance

The Global Fund describes itself as a public/private partnership. Constitutionally however, it was founded as a not-for-profit, private foundation in Switzerland and operated its Secretariat through an Administrative Services Agreement with the WHO. As described in Chapter 2, in 2004 the Global Fund concluded a Headquarters Agreement with the Swiss Government giving it “international juridical personality and legal capacity (The Global Fund 2004, p. 2),” meaning it became an international organisation.<sup>14</sup> By the end of 2008 it had concluded its agreement with the WHO and operated its Secretariat under its own auspices. Figure 5 depicts the evolution of the Global Fund’s institutional arrangements and its board composition. The Global Fund has matured, at least in a constitutional sense, from its private foundation beginnings to claim status as an independent, international institution.

Although the Global Fund’s board representation at global level embraces “communities of fate” described by Held and McGrew, its composition has changed since its inception to one where donor government delegations dominate. When the Global Fund was first set up, its board had 18 votes comprised of seven for donor government delegations, seven for recipient country delegations and four for non-state actors: one each for delegations representing developed country NGOs, developing country NGOs, private philanthropy and the private sector. As Figure 5 shows, by the end of 2005, this balance had shifted. Out of by then 20 voting members, eight seats represented donor government delegations, the number of recipient country delegations remained the same at seven and one more seat for a total of five had been added to those representing non-state actors. The eight delegations representing donor governments became Canada/Germany/Switzerland, Denmark/Ireland/Netherlands/Norway/Sweden, the European Commission, France/Luxembourg/Spain, Italy, Japan, United Kingdom/Australia and the United States. The additional non-state actor seat went to a delegation representing the ultimate

beneficiaries of the Global Fund's grants, a person or community living with or affected by HIV/AIDS, tuberculosis or malaria (The Global Fund 2005, p. 9).

**Figure 5: Evolution of the Global Fund's Board and Institutional Arrangements**



#### **The Global Fund to Fight AIDS, Tuberculosis and Malaria: Evolution of Board and Institutional Arrangements**

Given its inclusiveness and diversity, the Global Fund's board exhibits the "equivalence principle" where those affected by a global public good have a say in its provision (Kaul et al. 2003, p. 36; Held 2004, p. 371). Nevertheless, the dominance of donor governments raises the question of whether inclusion and 'having a say' is enough to serve as a legitimising force if the balance of power either functions as or is perceived as a "colonisation of power and wealth" (Wallace Brown 2010, p. 530). Bull (2010, pp. 226-7) supports this contention describing the Global Fund as an elite initiative where "the magnitude of money they [the elite] may bring in, or the potential influence and power to carry out desired policy change that they bring, may in itself tilt agendas toward the

priorities of the elite.” Where agenda setting is concerned there is a divergence between the idea of inclusiveness and the representation of the elite.

Therefore, rather than a source of input-oriented legitimacy which provides some form of global deliberative equality (Slaughter 2004a, p. 175), the Global Fund’s board can better be understood as a source of output-oriented legitimacy. The balance of voting power in favour of donor governments supports the Global Fund’s business model--its capacity to solve the problem of infectious disease and provide a collective solution to MDG 6 by mobilising and distributing funds. By the conclusion of its third replenishment cycle for 2011 to 2013, the countries comprising the donor government delegations on the Global Fund’s board had contributed 88% of the total pledges to the Global Fund, or just over US\$26 bn.<sup>15</sup>

The Global Fund’s country level governance model with its ‘country ownership’ ethos might more readily be seen as a form of input-oriented legitimacy (‘country ownership’ and the Global Fund’s in-country governance model are discussed in some depth in Chapter 5). Like the Global Fund’s board, it too departs from the ‘doctrine of sovereignty’ with CCMs, which act as the primary governance organ for Global Fund grants, encouraged “to be broadly representative of all national stakeholders in the fight against the three diseases” (The Global Fund, no date-b, p. 3). Even though as discussed in Chapter 2, Shakow (2006, p. 25) found that “[i]n practice, CCM leadership, composition and practices have varied widely”, at least by design the Global Fund has intended to create country-level governance which extends beyond government and expands the decision making domain to include national and international non-state actors such as local and international NGOs and CSOs.



The participation by non-state actors in direction-setting for a country's response to the three diseases could be seen as undermining the authority of government (Doyle and Patel 2008, p. 1935) and therefore detracting from both the structure and perception of input-oriented legitimacy associated with representation by and governance through the state. However, the inclusiveness and independence of CCMs can be seen as a basis for legitimacy to the extent that they create a "national public" (Keohane 2006, p. 16) for the provision of a global public good (Lipschutz and Fogel 2002, p. 136). Or, put another way, CCMs could be perceived as providing representation, where "political decisions are reached through a deliberative process where participants scrutinize heterogeneous interests and justify their positions in view of the common good of a given constituency" (Nanz and Steffek 2004, p. 315).

Where a national public is involved in designing and implementing far reaching programmes of prevention, treatment and care for the three diseases, its composition could be seen as an effort to improve public policy. However, inclusion of actors beyond the state in the Global Fund's country level governance, similar to the Global Fund's board, serves a highly practical purpose beyond the more normative desire to give voice to non-state actors. As Chapter 2 describes civil society has historically played a role in public health service delivery in weak infrastructure environments. Therefore, its inclusion in the Global Fund's country level governance is in part a problem solving strategy.

As the case in Malawi demonstrates, similar to the Global Fund's global level governance, the idea of inclusion may also depart from the reality of the influence of global and national elite. As discussed in Chapter 5, in Malawi in 2010 the CCM was chaired by the Secretary to the Treasury, and in addition to representation from national CSOs, it also included elite representation from government and the NAC, representation from

UNAIDS, the WHO and the Clinton Foundation, and participation from the United Kingdom's Department for International Development (DFID) and the United States' Center for Disease Control. As a representative on the CCM for an international organisation remarked, "[f]or me it's a bit challenging with the CCM at the moment. The [international] partner constituencies are fairly active and the other constituencies not so much and I'd really like to get those voices in, so it's not seen as an outside body but a Malawian institution" (International CCM Member 2010, interview, Lilongwe). Therefore governance at country level offers a mechanism for inclusivity, but in practice, it is more directly a source of output-oriented legitimacy involving 'multiple, nested and overlapping collective identities' but primarily those of elite national and international actors.

While CCMs are involved in country level direction-setting to fight the three diseases, they can only be effective problem solvers to the extent that they are successful in securing and overseeing Global Fund grants:

As the CCM we are responsible for the Global Fund resources in the country [Malawi]. The CCM has oversight for the Principal Recipients both in terms of programmatic and financial performance...The Global Fund does...hold us accountable for the country's implementation of the grant. Technically we are a Global Fund entity that also has Malawi ownership (International CCM Member 2010, interview, Lilongwe).

To remain viable, CCMs must be seen as legitimate in the eyes of the TRP who make grant award decisions, the Global Fund's board who approve the TRP's recommendations, the Local Fund Agents who provide an in-country audit function and the Geneva-based country managers who track and rate grant performance. Ultimately, this linking of legitimacy to country-level accountability for proper management of the funds and

implementation of effective interventions is reassurance to donors that the ‘national public’ of a country is behaving in a way that Suchman (1995, p. 574) would describe as “desirable, proper, or appropriate.” Legitimacy in the eyes of wealthy and powerful states is imperative for country level governance too.

The Global Fund’s inclusion of state and non-state, public and private and national and international actors in its global and country level governance departs from the ‘states as members’ model of traditional multilaterals. This inclusiveness responds to Keohane’s concern with the limits of the “sociological legitimacy of statism” through the participation of a range of actors beyond states in decision making. But in the case of the Global Fund, this inclusiveness has a twist. Normatively, it may be seen as a good thing, embracing the ‘communities of fate’ who are affected by the three diseases and deflecting the criticism levelled towards traditional multilaterals that their state-centric governance excludes large numbers of people and interests. But behind this belief in the goodness of inclusion is elite participation and influence and a strong output-oriented legitimacy which serves the Global Fund’s *raison d’être* as a financing mechanism to mobilise funds on an unprecedented scale primarily from donor governments. As such, the Global Fund’s model of inclusion at global and country levels is a new source of legitimacy distinct from multilaterals. This legitimacy does have an input-oriented character to the extent that it fulfils the ‘equivalency principle’. However, it also has a strong output-oriented function and when the question of “legitimacy in whose eyes?” is posed, at both global and country levels, the answer is in the eyes of wealthy and powerful states.

#### The Global Fund, Legitimacy, Transparency and Performance-based Funding

As discussed in Chapter 2, the Global Fund’s *modus operandi* of transparency together with its performance-based funding model were features of its design intended as a change

from ‘business as usual’, a signal that the Global Fund was a departure from what were perceived as slow and overly bureaucratic practices of multilateral organisations in which some donor countries had lost faith (Buse and Walt 2001a, p. 551; WHO 2002, p. 1, Kickbusch 2009, p. 323). Like the Global Fund’s inclusive governance model, transparency and performance-based funding which are inextricably linked to ideas of participation and accountability, are new legitimising forces distinct from those of traditional multilaterals (Woods and Narlikar 2001, p. 575; Nanz and Steffek 2004, p. 323; Fidler 2004, p. 802; Steffek and Nanz 2007, p. 10; Sridhar, Khagram and Pang 2008, p. 9). As Chapter 2 describes, beyond being seen to provide an opportunity for participation from a broad public, transparency and performance-based funding inform a critical advocacy and communications function, a legitimising force, helping to make the Global Fund’s case to donor governments and other partners.

Transparency through its association with participation and accountability is construed as making processes of international organisations more deliberative or more democratic particularly where the inclusion of NGOs and CSOs is concerned (Woods and Narlikar 2001, p. 575; Moravcsik 2004, p. 342; Nanz and Steffek 2004, p. 321; Slaughter 2004a, p. 169; Sridhar, Khagram and Pang 2008, p. 9). These arguments characterise NGOs and CSOs as constituents of a ‘public sphere’ which is comprised of overlapping transnational communities beyond the boundaries of states (Castells 2008, p. 78). As discussed earlier in this Chapter, NGOs and CSOs are seen as providing a two-way “transmission belt” with international organisations, “giv[ing] voice to citizens’ concerns and channel[ing] them into the deliberative process of international organizations” and “mak[ing] internal decision-making processes of international organizations more transparent to the wider public” (Steffek and Nanz 2007, p. 8). This faith in the powers of transparency is related to a belief in the capacity of deliberative processes to make better decisions and better policy

(Woods and Narlikar 2001, p. 574; Nanz and Steffek 2004, p. 317; Held and Koenig-Archibugi 2004, p. 127; Slaughter 2004a, p. 175; Wallace Brown 2010, p. 513).

Transparency presented in this context is a form of input-oriented legitimacy, where it is seen to strengthen participation by non-state actors and diversify the discourse beyond the natural boundaries of state-centric representation.

Not all scholars agree that deliberative governance processes give rise to ‘better’ governance. Risse (2004, p. 311) argues that deliberative strategies of inclusion still have the problem of determining who the stakeholders are (or should be), whom they actually represent, and to whom they are accountable. Kahler (2004, p. 153) echoes this sentiment noting that affording NGOs, particularly those originating in developed countries, greater participation in the governance of international organisations could further augment the power which accrues to wealthy states. Held (2004, p. 370) observes that for poor countries or delegations, having a seat at the table does not ensure effective representation: “...developed countries have large delegations equipped with extensive negotiating and technical expertise, while poorer developing countries often depend on one person delegations, or have even to rely on the sharing of a delegate.” Given these criticisms, it’s not surprising that Moravcsik (2004, p. 343) maintains that deliberative democracy is a normative, utopian ideal. Stone (2008, p. 23) provides some perspective by describing a continuum with hierarchically based realist-rationalist views of governance at one end and deliberative models with an idealist cosmopolitan character at the other and a “...complex range of state capacities, public action and democratic deliberation fall[ing] in between these two extremes.” While transparency is argued by some to support more deliberative processes, not all agree that deliberative processes make for inherently ‘better’ governance.

The Global Fund has as one of its principles to “...operat[e] in a transparent and accountable manner based on clearly defined responsibilities” (The Global Fund, no date-c, ‘The Framework Document, p. 2). The Framework Document repeatedly describes the Global Fund’s processes as transparent—those for applications, channelling of funds, monitoring and evaluation and fiduciary arrangements and audits. In and of itself, this intention to make available information about oversight, decision-making and performance does not necessarily make the Global Fund more representative, more responsive or more accountable. In Hale’s (2008, p. 73) words, “[i]f “democracy deficit” is the catchphrase for global governance’s problem, “transparency” is its buzzword solution.” As a legitimising force, transparency has legitimising and output-oriented qualities to the extent that it makes apparent internal decision-making and outcomes to a ‘global public’ and is therefore perceived as contributing to greater representativeness, fairness, and equity (Woods and Narlikar 2001, p. 583). However, critics (Kahler 2004, p. 144; Risse 2004p. 312) challenge these normative attributes as overly idealised.

Performance-based funding forms the basis for the Global Fund’s capability to measure and report results achieved through its grants, making the case to donors that by investing in the Global Fund meaningful progress can be made towards achieving MDG 6. The Global Fund is not unique in its drive to demonstrate outcomes. As discussed in Chapter 2, the WHO and other UN organisations also mobilise donor funds and seek to present ‘value for money’ arguments for their programmes and initiatives. Piot (2008, p. 527) described this process for UNAIDS: “...the span of public and political attention is generally short... To maintain the AIDS response as a priority we need to show continual results on the ground—i.e....the major investments made in fighting AIDS are having a commensurate effect in terms of averted infections, illness, and deaths.” Proving performance or laying claim to the results of its own good works lends legitimacy to the

Global Fund particularly in the eyes of donors by reinforcing the belief or ‘proving’ that investing substantial resources yields results in the fight against HIV/AIDS, tuberculosis and malaria.

As described in Chapter 2, the Global Fund was initially conceived as a vertical, disease-focused financing mechanism. Vertical programming lends itself to performance-based funding because it is possible to isolate and monitor and evaluate results such as how many people began anti-retroviral treatment, or whether prevalence or incidence of HIV/AIDS is trending up or down in a given population.<sup>16</sup> However, more complex questions of health system performance are challenging to measure in part because so many dynamic and interrelated factors are at play, and also because of the long time horizon necessary for these types of investments to yield change. As Gonzalez noted in his 1965 work for the WHO on mass campaigns (vertical programming), “...mass campaigns are useful...in breaking the vicious circle...[but mass campaigns] are temporary expedients...and...there is a need to establish... an organized scheme of general health services which, though not yielding spectacular results, form an essential component of the permanent public services of the community” (WHO 2005, p. 318). Sridhar and Batniji (2008, p. 1190) take things a step further positing that donor interest in “quick results and measurable returns through vertical programming” actually discourages investments in longer-term and “essential” health services and infrastructure. In the words of Brugha et al. (2004, p. 100),

[t]he pressure to show results through performance based disbursement is understandable, as a prerequisite for accountability. A similar condition underlies the Fund’s [the Global Fund’s] own relation with its contributors, in that its ability to attract additional contributions will depend on it showing results. Excessive or too frequent reporting requirements will be beyond the capacity of countries with weak systems that have the greatest need for additional funds.

Performance-based funding is an output-oriented legitimising force particularly in the eyes of donors, a blessing in the Global Fund's virtuous cycle of 'raise it, invest it, prove it'.

However, performance-based funding will be difficult to maintain if it cannot be reconciled with essential and more complex investments in health systems and infrastructure that will yield less 'spectacular' results.

For the Global Fund, transparency and performance-based funding have two legitimising functions. Transparency, in theory at least, relates to creating 'better' policies through facilitating more deliberative governance and discursive processes and from this perspective can be seen to be input-oriented. Whether or not this is in fact the case, the belief in or perception of the goodness of transparency has a legitimising effect.

Performance-based funding on the other hand is a more consistently output-oriented force where results--particularly related to disease-focused interventions—are the basis for the case to donors for sustaining their investment.

### The Global Fund, Legitimacy and Resource Mobilisation and Distribution

As has been discussed in Chapter 2, the scale of the Global Fund's resource mobilisation for three diseases is without precedent. By the end of 2009 the Global Fund had mobilised more than US\$21 bn in commitments and approved US\$19.3 bn in grants to 144 countries (The Global Fund 2010k, 'Resource Mobilization'), making more resources available to combat HIV/AIDS, tuberculosis and malaria than any other UN or Bretton Woods institution. Chapter 2 describes the Global Fund's resource mobilisation including increased donor government funding for the health envelope overall, and competition for ODA over and above health among other sectors such as climate change and food security. The sources of the Global Fund's legitimacy, its inclusive governance at global and country levels, and its transparent and performance-based funding modus operandi serve to



reinforce the Global Fund's resource mobilisation and distribution, which lie at the heart of its mission, its design and its sustainability.

As a financing mechanism to achieve MDG 6, the Global Fund as it was first conceived was an emergency response to a humanitarian disaster; however donors have signalled a change in this approach. In 2001 there were estimated to be 28 million people living with HIV/AIDs, and 20 million of those were in Sub-Saharan Africa (UNAIDS 2010d, p. 180). By 2009 these figures had grown to 33 million people living with AIDS worldwide of which 22 million were in Sub-Saharan Africa. Since 2004, largely due to the Global Fund and PEPFAR, almost 5 million people have access to treatment reducing deaths by 19% (UNAIDS 2010c, p. 8). Despite these astonishing figures, or perhaps because of them, donors have signalled a move away from funding an 'emergency response' to a longer term view of their commitments with a focus on effectiveness and efficiency, the responsibilities of recipient countries, and more specifically, their accountability. Simply, the more people who begin to receive treatment for AIDS the more people there are on these drugs for their lifetimes. This means donors, some of whom like the United States which have annual commitment cycles, must consider long term investment horizons. As a 2010 UNAIDS report (2010b, p. 2) which contextualised the HIV/AIDS response relative to all the MDGs stated,

[f]or decades, HIV has been addressed as a global public health crisis requiring an emergency response. This approach has been a powerful motivator for mobilising resources and expanding HIV programmes, and it remains relevant in many contexts. Donor priorities, however, appear to be shifting, often away from MDG 6 and towards other health-related MDGs and development challenges. Donor allocations are increasingly subsumed in sector-wide funding, used for health

systems strengthening or are being allocated to those MDGs considered to be veering the farthest off track, like maternal and child health.

For the Global Fund with its distinctly output-oriented legitimacy, this change in donor strategy means that the nature of the case it makes for resources must also change.

The Global Fund's "capacity to solve problems which require collective solutions" (Scharpf 1999, p. 11) is fundamentally dependent on powerful states. The United States has provided 28% of donor government resources since the Global Fund's inception. For example, the United States pledged US\$4 bn towards total donor government commitments of US\$11.7 bn in the Global Fund's third voluntary replenishment cycle for 2011 to 2013. This contribution came with an agenda for reform which is being implemented by the Global Fund under the banner of "The Agenda for a More Efficient and Effective Global Fund" (The Global Fund 2010m, p. 15). Among the conditions laid out by the United States were reforms to the Secretariat to "...improve quality control, transparency, [and] accountability", and to "Board constituencies and the institutions they represent...to improve Global Fund processes and policies around proposal development, review, and funding...[and for ]...the Secretariat, grant recipients, development partners, and UN and other technical partners...[to] improve how we work together at country level..." Lastly, the United States laid out the task for implementing countries of "...leadership in defining and advancing reforms that will result in true improvements at the country level to support the development, implementation, and review of strategic, high-quality, and cost-effective grant programs" (PEPFAR 2010b, 'Investing for Impact'). In essence, the United States defined its expectations of the Global Fund, other donor governments, non-state actors and recipient countries in order for the Global Fund to continue to receive the level of investment it requires. Legitimacy in the eyes of donor

governments is important for the Global Fund, but legitimacy in the eyes of one of its voting board members, the United States, is of a higher and more far-reaching order.

In times of fiscal constraint the expectations set by donor governments for how their money will be spent means that for recipient countries the nature of country ownership is becoming increasingly associated with accountability. The General Assembly of the UN resolved in its 2010 review of progress towards achieving the MDGs “to promote and strengthen national ownership and leadership of development as a key determinant of progress...with each country taking the primary responsibility for its own development” (United Nations 2010, p. 7). A similar sentiment was expressed in a report to the United States government by the Institute of Medicine (2010 ‘Sharing the Responsibility’): “Shared responsibility between the United States and African nations will empower these nations to take ownership of *their* [italics mine] HIV/AIDS problem and to work to solve it.” While the solution may be collective, the problem is becoming increasingly isolated, attributed to poor and disease endemic countries.

Recipient countries are being challenged to prove that the significant investment they have received to address HIV/AIDs and the other diseases are in addition to their own commitments amid concerns that increased development assistance for health has been accompanied by a decline in spending by recipient governments on health (Lu et al 2010, p. 1382). Sridhar and Woods (Sridhar and Woods 2010, p. 1326) have sounded a note of caution about these conclusions, particularly where the heavy hand of donor governments might influence a recipient government’s budget priorities in an effort to direct donor investments more explicitly:

...who should decide and who takes responsibility for setting priorities?...Messing up good intentions are vested interests, pressures to disburse funds, a prioritising of

efforts most likely to show measurable results in a short-time scale, and political incentives to announce new initiatives even if that means abandoning successful policies.

The reminder here is that international institutions like the Global Fund are not above “messaging up good intentions” or immune to the “realities of power politics” (Keohane 2006, p. 5), particularly when proving their own cases to powerful and wealthy states.

For the Global Fund the legitimacy it derives from mobilising and distributing resources is changing. While it has always been donor driven, it is becoming more explicitly dependent on the United States to confer it. The case that underlies the Global Fund’s resource mobilisation is also on shifting ground. In addition to reporting on how its investments have scaled up prevention, treatment and care for three diseases and saved lives, the Global Fund must make a much broader case for the efficiency and effectiveness of its investments. It must place its achievements in the context of factors that are within its scope of influence, like better grant processes, as well as those that are outside of its control but perhaps subject to influence, such as the national budget allocations of recipient countries. The Global Fund’s distinct form of output-oriented legitimacy is becoming inherently more complex as donor interests move away from that of an emergency response. “The gap between U.S. ability and patient needs is one reason that the [United States’] administration has emphasized a need to get other donors on board... Kazatchkine [the Global Fund’s Executive Director from 2007 to 2012] called it “a big test for multilateralism and the move to multilateralism for the administration”” (Dickinson 2010, p. 4).

The nature of the Global Fund’s legitimacy may not be as it initially appears or as it might claim. Its inclusive governance at both global and country levels in particular would seem

to distinguish it from the ‘doctrine of sovereignty’ model of traditional multilaterals, and normatively at least suggests that rather than “exclude large numbers of people...on a global basis” (Keohane 2006, p. 14), it can claim to include them. However, at global level in particular, the domination of donor governments on the Global Fund’s board suggests that in addition to serving the “equivalency principle”, the board reflects the nature of the Global Fund’s output-oriented legitimacy and in particular serves its resource mobilisation efforts. At country level, inclusiveness can be seen to support a more deliberative approach to decision-making. In addition to being a practical strategy to include non-state actors on which successful service delivery depends, it is also in Malawi’s case largely an inclusion of government and international elites. In both cases what initially appears to be input-oriented legitimacy offers strong normative overtones implying inclusion and participation, but it is in essence output-oriented legitimacy which is held in the eyes of donor governments.

Similarly, the Global Fund’s transparency and the information it makes available about oversight, decision-making and performance can be seen as having input-oriented qualities to the extent that it contributes to greater representativeness, fairness and equity; however, transparency does not necessarily result in ‘better’ governance than that practised by traditional multilaterals. Like inclusive governance, transparency lends a normative ideal and grounds for legitimising claims by the Global Fund of deliberative decision making and discourse. Performance-based funding on the other hand is more consistently an output-oriented force, nevertheless it also lends itself to claim-making, in this case about the Global Fund’s own good works. It forms the basis of the Global Fund’s case to donor governments particularly for vertical, disease-focused interventions and as such is intrinsically tied to the Global Fund’s resource mobilisation and its legitimacy in the eyes of donor governments. The Global Fund’s legitimacy then in terms of transparency and

performance-based funding is derived both normatively and rationally and is distinctly output-oriented.

Inclusive governance at global and country levels, transparency and performance-based funding all serve to underpin the Global Fund's resource mobilisation efforts. As the tenor of donor governments and particularly the Global Fund's largest donor, the United States, has changed from that of providing an emergency response to one of efficiency, effectiveness and country responsibility, the nature of the Global Fund's legitimacy, despite claims of inclusiveness and transparency not only becomes more explicitly output-oriented but also more explicitly held in the eyes of the most powerful and wealthy states. As Kazatchkine noted, it's a big test for multilateralism (Dickinson 2010, p. 4), one that although lacking the legitimacy conferred by the doctrine of states nevertheless must provide a collective solution to MDG 6 on which millions of lives, or 'communities of fate', depend.

### **3. The Global Fund, Legitimacy and the Accountability Link**

Before discussing the link between legitimacy and accountability, some clarification of what is meant by accountability is necessary. Accountability is variously associated with legitimacy, transparency, democracy, responsibility and a host of other concepts, and is attributed to individuals, organisations, and sectors. Although an in-depth analysis of accountability is beyond the scope of this discussion, Bovens offers a conceptual framework for accountability which provides a useful lens. He differentiates between two types of accountability. The first is what he calls an active form of accountability—accountability as a virtue (Bovens 2010, p. 949). The second is what he calls a passive form of accountability—accountability as a social mechanism (Bovens 2010, p. 948). In the case of the former, accountability is "...a normative concept, a set of standards for the

evaluation of the behaviour of public actors” (Bovens 2010, p. 951). Bovens (2010, p. 949) notes that the normative use of accountability conveys an image of transparency and trustworthiness, but it is also highly contested because it “lacks standards for accountable behaviour, and because these standards differ, depending on role, [it also lacks] institutional context, era, and political perspective.” This normative aspect of accountability is analogous to the normative qualities of legitimacy.

In the case of the latter type of accountability—as a social mechanism—Bovens (2010, p. 948) defines it as “an institutional relation or arrangement in which an actor can be held to account by a forum.” This type of accountability has historical roots which Dubnick (2007, p. 14) ascribes to the Norman conquest of England when property holders listed their assets in the Domesday books, or provided their ‘account’ to the sovereign. The principal-agent legacy is embedded in this historic and mechanistic interpretation of accountability. Accountability as a mechanism is often characterised as determining who it is that should be held to account, to whom they are accountable and what sanctions can be employed to hold an individual or an institution to account (Held and Koenig-Archibugi 2004, p. 127; Buchanan and Keohane 2006, p. 426; Bartsch 2007b, p. 6). As Buse and Walt (2000b, p. 705) note in their work on global public private partnerships, accountability in its mechanistic form may seem straightforward in concept, but may prove difficult to achieve:

...accountability within public-private partnerships may be less straightforward, partly because of the distance between the global partners and the beneficiaries, and the length of time needed for any impact to be felt...partnerships whose goals and division of labour are vaguely defined will lack accountability. Moreover, actually holding a partner accountable presents difficult challenges. At the moment

systems of sanctions that can be applied to negligent partners do not appear to have been developed.

Conceptually then, accountability resembles legitimacy in the sense that it has two aspects. It is normative, conferring virtue shaped by the belief or perception that an individual or entity is accountable. It is also rational, derived through mechanisms or processes that embed a principal-agent relationship between the accountable and those who hold them to account.

In the case of the Global Fund, both concepts of accountability—as a virtue and as a mechanism—are relevant. Accountability as a virtue fosters belief in the Global Fund’s legitimacy: it imbues the Global Fund with the qualities of a ‘good governor’, one that is seen by its constituents to practise inclusive governance and provide a voice to non-state actors, embracing both global and country level publics; one that practises transparency and can demonstrate human and moral outcomes in terms of lives saved; and one that can effectively mobilise and distribute resources on an unprecedented scale. The output-oriented nature of the Global Fund’s legitimacy relies on accountability as a mechanism. The Global Fund must have in place the processes to provide assurance that it is managing donor money responsibly and effectively and donors are realising the results they intend. According to Bovens (2010, p. 962), both types of accountability have to do with “...transparency, openness, responsiveness, and responsibility. In the former case [accountability as a virtue], these are properties of the actor, in the latter case [accountability as a mechanism] these are properties of the mechanisms or desirable outcomes.”

Because of its predominantly output-oriented legitimacy, the Global Fund emphasises the mechanistic aspects of its accountability, but its normative character is not lost.



Kazatchkine (Council on Foreign Relations 2010, ‘A Conversation with Michel Kazatchkine’) described the accountability embedded in the Global Fund’s grant award process:

...everything that we would fund is evidence-based, so all of the requests that come to the Global Fund are screened and then carefully assessed by an independent panel of international experts from the north and from the south...that will look for how programmatically, epidemiologically, scientifically and financially a proposal is sound...[The grant application and review process] allows our board to decide on investments that actually have 85 per cent chance for the programs to reach their objectives. And that's I think a very strong message to our donors.

Normatively, Kazatchkine claims the validity, or virtue, of the Global Fund’s decision-making processes as both inclusive and valid. He also emphasises the Global Fund’s results orientation, its output-oriented legitimacy, linking it to the board’s accountability to donor governments to spend their money wisely. The legitimacy of the Global Fund’s model is bound closely to accountability, both as a ‘virtue’ and as a ‘social mechanism’.

#### The Global Fund’s Accountability: Mechanistic Strength

The historic notion of a principal-agent relationship is embedded in several conceptions of accountability applied to international organisations. Cox and Jacobson (1973) make a connection between the design of an organisation and the nature of its accountability or decision-making. Grant and Keohane (2005) take a different approach, focusing on the nature of the decision making processes themselves, describing them as being either modelled on participation or delegation. Keohane (2002) examines the accountability of traditional multilaterals from the perspective of their internal accountability practices and their external accountability to those affected by an institution’s decisions. These

perspectives on accountability may seem divergent, but what they share is what Bovens would describe as their mechanistic orientation.

Cox and Jacobson (1973, pp.429-30) describe three types of models for the structure of influence and decision-making or accountability in international organisations: i) the monarchic model which is “characterized by the importance of the executive head and of the other actors who belong to the organization’s establishment, regardless of whether they are members of the international bureaucracy, representatives of states and other entities, or independent personalities”; ii) the oligarchic model where the “activities of such agencies are considered highly salient by the most powerful states...[and where these] agencies create rules with important consequences which apply to the states and others”; and iii) the pluralistic-bargaining model where influence is “diffuse and fluid [and] [w]hat goes on in the organization can be explained largely in terms of the participant subsystem, but there is no single network through which this subsystem is manipulated, no cohesive establishment.” From the earlier discussion on the Global Fund’s sources of legitimacy, the Global Fund’s inclusive governance suggests that it takes on the characteristics of the third model, that of pluralistic-bargaining. However, Cox and Jacobson (1973, pp.430) assert that since the activities of pluralistic-bargaining organisations do not affect powerful states this reduces the interest of these states in playing a leadership role and moreover might contribute to them conspiring to limit the power of these organisations. This is not the case for the Global Fund.

If the dominant representation of donor country delegations on the board and the influence of the United States in setting performance expectations are considered, then the Global Fund could be said to resemble an oligarchic organisation where its tasks are

“carefully monitored by representatives of the states” and “state policies rather than the participant subsystem” (Cox and Jacobson 1973, pp.430) explain decision-making. In practice, the Global Fund’s model is found somewhere in between Cox and Jacobson’s concepts of pluralistic-bargaining and oligarchic models. Arguably, this straddling or mixing of ‘bottom up’ and a ‘top down’ is due to the effects of globalisation which have emerged more strongly since Cox and Jacobson’s work—and in the case of global health governance, the realisation that “states alone cannot address many of the health challenges...[including] [i]nfectious diseases [which] are perhaps the most prominent example of this diminishing capacity” (Dodgson, Lee and Drager 2002, p. 7).

Grant and Keohane (2005, pp. 31) distinguish between two models of accountability: participation and delegation. They describe the fundamental difference between the two as lying in the answer to the question “[w]ho is entitled to hold the powerful accountable?” In the participation model, the performance of what Grant and Keohane call a ‘power-wielder’, is evaluated by those who are affected by its actions. In the delegation model performance is evaluated by those entrusting an entity with power. In ascribing either model to the Global Fund, the challenge lies in defining the ‘who’ in terms of who is affected by or who entrusts the Global Fund with power. According to Grant and Keohane (2005, p. 33), in the global context this ‘who’ is a challenge because “[i]n the absence of a public whose boundaries are defined by participation in a polity, it is very difficult to specify either who should be entitled to participate or how they would do so.” In other words, depending on one’s point of view, the Global Fund has different principal-agent identities. As principals, donor governments hold the Global Fund to account. As the principal itself, the Global Fund holds recipient countries to account. But there is no principal-agent relationship that embraces broader global or country level ‘publics’.

This challenge in defining a global public for the purposes of accountability is perhaps why Grant and Keohane find that multilateral institutions adopt a mix of both participation and delegation models of accountability. For the Global Fund, the inclusive nature of its global and country level governance models suggests participatory accountability where state and non-state, public and private and global and country actors have a say in decision-making. However, the influence of powerful states particularly on its board and its predominantly output-oriented legitimacy are evidence that a more delegative form of accountability is at play. Grant and Keohane (2005, p. 33) note that the role of powerful states is particularly complex where accountability in international institutions is concerned because "...governments are accountable to their citizens and to an array of domestic interests and institutions, but...this does not assure accountability to outsiders." In terms of participation and delegation, the Global Fund's accountability model is similar to that of traditional multilaterals in the sense that it exhibits aspects of both and faces the challenge of balancing the influence of wealthy and powerful states with the interests of 'outsiders'--those who are reliant on donor government funding and Global Fund grant processes to provide prevention, treatment and care for the three diseases.

The nature of the Global Fund's output-oriented legitimacy--its problem-solving and outcome focus--supports a hierarchical form of accountability which Keohane (2002, p. 14) describes as 'internal': where "entities [can be held] accountable because the principal is providing legitimacy or financial resources to the agent...[and] the principal and agent are institutionally linked to one another." The Global Fund's internal accountability has several components. At country level, not only do countries report their results in order to release further tranches of funding, but these results are overseen by the Principal Recipient, the CCM and audited by a Local Fund Agent. At global

level a TRP comprised of independent experts determines grant awards and Secretariat staff score grant performance. In addition, there is an independent Office of the Inspector General, which serves an audit role for the Secretariat and country grant portfolios and reports directly to the board. All of these bodies and processes not only support the nature of the Global Fund's output-oriented legitimacy, but in and of themselves are mechanisms for a principal-agent model of accountability. In this hierarchy, the donor government dominated board can hold the Global Fund to account for its operational efficiency and the effectiveness of its grants to recipients. The Global Fund in turn can hold its Principal Recipients to account for exercising their fiduciary responsibilities and for achieving goals for the three diseases. The Global Fund's legitimacy, particularly that conferred by its global and country level governance models and its performance-based funding approach, is reinforced by its ability to demonstrate what Keohane defines as an internal form of accountability, or what Kazatchkine describes as "...a very strong message to our donors."

#### The Global Fund's Accountability Gap: The Necessity of Virtue

The Global Fund's 'publics' challenge the neatness of a principal-agent concept of accountability (Benner, Reinicke and Witte 2004, p. 198; Slaughter 2004b, pp. 133-4; Zürn 2004, p. 273; Grant and Keohane 2005, p. 33; Bartsch 2007b, p. 8). As its inclusive governance model demonstrates, the Global Fund is not purely a state-centric multilateral in terms of the state and non-state delegations who vote on its board or in terms of the 'national publics' it has created at country level. As Scharpf described, it must contend with a "thin" collective identity and the "multiple, nested or overlapping" constituencies who have an interest in the resources it invests and the results its grant recipients achieve. According to Held (2004, p. 371), there is a breakdown "...between decision-makers and

decision-takers, between decision-makers and stakeholders, and between the inputs and outputs of the decision-making process.” Keohane (2002, pp. 14-15) describes the accountability of an entity relative to its publics as ‘external’ accountability, or “accountability to people outside the acting entity, whose lives are affected by it.” (The external accountability challenge as it relates to country ownership is discussed in Chapter 5). He argues that in the case of multilateral organisations, it’s not that they are not accountable, because they have internal accountability processes. Rather, it is a question of to whom they are accountable beyond the states that comprise their formal governance and then how they are held to account. “These organizations are subject to accountability claims from almost everybody, but in the last analysis they are in fact accountable, through internal processes, only to a few powerful states and the European Union” (Keohane 2002, p. 19). The Global Fund then, despite its inclusive approach to governance, has a gap in its external accountability. Like traditional multilaterals, its external accountability relative to its ‘publics’ and people whose lives it affects is lacking.

From an internal accountability perspective, the sanction that the Global Fund faces for poor performance or ‘bad governance’ is a restriction, reduction or delay in contributions from donor governments. From an external accountability perspective, much has been made of the power of transparency to enable a form of reputational sanctioning (Florini 2003, p. 196; Barnett and Finnemore 2004, p. 170; Koenig-Archibugi 2004, p. 237; Scholte 2004, p. 217; Grant and Keohane 2005, p. 39). Through Bovens’ lens, transparency can confer virtue on an organisation, or form the basis of a normative claim (Barker 2000, p. 9) that it is ‘open, responsive, and responsible’. The premise for the virtue of transparency is that civil society, for example NGOs and CSOs who deliver services to or advocate on behalf of those infected with HIV/AIDS in a developing country, can access information on oversight, decision-making and performance and then use this

information to influence the beliefs or perceptions about the Global Fund's ability to make fair and effective decisions about the grants it awards or the funds it releases. While in concept, civil society can use the power of information and advocacy to play a sanctioning role (Nanz and Steffek 2004, p. 321; Scholte 2004, p. 219; Blas et al. 2008, p. 1686; Castells 2008, p. 79), for the Global Fund this may not be as potent in practice. Wallace Brown (2010, p. 525) observes that,

...there also seems to be an even larger deliberative gap between the Global Fund as an organisation and those most affected by its decisions (stakeholders outside of the Global Fund board). In most cases, the opportunities for deliberation are seldom and when they do exist, they are generally informal...It is only at the Global Partnership Forum every two years, where stakeholders might be able to communicate directly with members of the Global Fund secretariat, the Global Fund board and in some rare cases, high level representatives of donor nations.

There are examples in the international realm where civil society has had significant effect exercising its sanctioning power however, even in some of the most cited examples such as the World Commission on Dams (Khagram 2000, p. 83), the process has taken decades and is anything but a neat, linear cause and effect model. In addition, in most organisations, including the Global Fund, there are a range of activities and decisions taken where those affected are unlikely to impose any form of reputational sanction either because they are not privy to all or at least some pertinent information or they do not participate in certain fora. Moreover, in the case of the Global Fund, civil society organisations may be beneficiaries and their own interests in the aid relationship may discourage them from a sanctioning role. Apart from the potential barriers to NGOs or CSOs, there is also an inherent bias against the sanctioning power of the broader 'public' and particularly the poor who are unlikely to have access to information and exercise

reputational sanctions because of a lack of technology, education or social status. So while in theory, the power of transparency to address the external accountability gap may be compelling, in the case of the Global Fund it is unlikely to be entirely satisfactory in practice. As Cardoso (2003, 'UN High Level Panel on UN-Civil Society'), the Chair of the UN's High Level Panel on UN-Civil Society noted: "In the final analysis, they [civil society] are what they do. The power of civil society is a soft one. It is their capacity to argue, to propose, to experiment, to denounce, to be exemplary. It is not the power to decide."

For the Global Fund, its internal accountability in particular reinforces the output-oriented nature of its legitimacy. It is a 'social mechanism' form of accountability hierarchically linking who is accountable to whom between recipients and the Global Fund and the Global Fund and donor governments. However, the Global Fund also relies on accountability as a 'virtue' which has an interdependent relationship with its sources of legitimacy, in particular its inclusive governance model and its ethos of transparency. This 'soft power' form of accountability can ease the Global Fund's external accountability gap--if not address it--by reinforcing the belief in, or perception of the Global Fund as 'open, responsive and responsible' a claim which in turn obscures its external accountability gap. As Grant and Keohane (2005, p. 40) maintain, accountability for international organisations is not straightforward and some ingenuity is necessary as is some tolerance for imperfection: "accountability that is both effective and widely viewed as legitimate will remain elusive."

#### **4. Conclusion**

The Global Fund's innovative design provides for its distinct sources of legitimacy. At first glance, the Global Fund's efforts to reflect the interests of its many constituencies and its



inclusiveness beyond the traditional ‘states as members’ model of many multilaterals appears to be a form of input-oriented legitimacy. However, on closer examination, the Global Fund’s legitimacy is largely output-oriented, strongly focused on donor governments and the necessity of ‘proving’ its outcomes and accomplishments. Consequently, despite its innovative design and the inclusion of non-state actors in its governance at global and country levels, the Global Fund’s legitimacy is conferred predominantly by and is therefore reliant on donor governments.

The Global Fund’s inclusive governance and its transparency and performance-based funding underpin the success of its resource mobilisation. As the tenor of donor governments and particularly the Global Fund’s largest donor, the United States, has changed from that of providing an emergency response to one of efficiency, effectiveness and country responsibility, the nature of the Global Fund’s legitimacy not only becomes more explicitly output-oriented and subject to the Global Fund’s own legitimating, but also more explicitly held in the eyes of the most powerful and wealthy states. As Kazatchkine, noted, the tension created by what was described in Chapter 2 as the ‘treatment mortgage’ for donor governments is a big test for multilateralism and one on which millions of lives, or ‘communities of fate’, depend.

For the Global Fund, its strong internal accountability model is reinforced by the output-oriented nature of its legitimacy. It hierarchically links who is accountable to whom between recipients and the Global Fund and the Global Fund and donor governments. However, the Global Fund also relies on accountability as a ‘virtue’ which has an interdependent relationship with its sources of legitimacy, in particular its inclusive governance model and its ethos of transparency. This more normative form of accountability supports the belief in or perception of the Global Fund as a ‘good governor’.

These normative and legitimating aspects of its accountability serve in part to obscure the Global Fund's external accountability gap rather than lay bare what Rosenau describes as the "powerful tensions, profound contradictions, and perplexing paradoxes" of an emergent global governance model.

## **Chapter 4 - Malawi: Intractable Circumstances and an Elusive Aid**

### **Architecture**

#### **1. Introduction**

Donor influence in policy development raises a number of questions concerned less with the technical merit of alternative policy options for such issues as health financing strategies and the composition of essential drugs lists, than with issues of accountability, sovereignty, information, sustainability and appropriateness in the health policy domain (Okuonzi and MacRae 1995, p. 130).

Malawi is a landlocked country of 14.9 million people (World Bank 2010b, 'World Development Indicators: Malawi') in south east Africa bordered by Tanzania, Mozambique and Zambia. It is a new democracy challenged by intractable circumstances including a weak agricultural economy which renders the population vulnerable to food insecurity, a stable but precarious debt situation, a burgeoning population and one of the highest HIV/AIDS prevalence rates in the world at just under 12% (World Bank 2010, Health Nutrition and Population Statistics). In light of its political, economic and social challenges, Malawi's scaled up HIV/AIDS response and the Global Fund's role in financing it could offer evidence of an emerging aid architecture which Bourguignon and Sundberg (2007, p. 319) describe having two features: one is the country's ownership of its development strategy [here implying that the strategy is reflective of the priorities identified and set by a country] around which donors align and the second is the allocation of aid based on performance.

The trajectory of Malawi's response to its HIV/AIDS epidemic, from its early history and initial, imperfect policy framework to its subsequent achievements in reducing prevalence

to just under 12% (World Bank 2010, Health Nutrition and Population Statistics) and dramatically scaling the number of people receiving treatment tell a story of significant new investment and intensified institutional complexity. While results have been achieved, Malawi's HIV/AIDS response and the Global Fund's role demonstrate the practical challenges that arise when a "combination of new aid instruments and the emergence of new players" (Bonnell 2009, p. 165) occur in a low income country with weak infrastructure. Although Malawi, with the Global Fund's support, has dramatically scaled up its HIV/AIDS response, those whose lives are affected remain vulnerable. Their needs and circumstances are subject to the political interests and interplay among an elite collection of state and non-state and national and international institutions including the Global Fund suggesting that an emerging aid architecture may be more elusive than some believe.

The first section of this chapter describes Malawi's intractable circumstances, its early HIV/AIDS history and its reliance on aid particularly for health. The second section describes the context for Malawi's scaled up HIV/AIDS response, situating it within the broader health sector, its reliance on donor support and the challenges associated with the Global Fund's 'fit' with and influence on Malawi's Health Sector Wide Approach (SWAp). The last section of the chapter describes the complexity and dynamics of Malawi's institutional landscape, and its vulnerability to the sustainability of Global Fund support. The chapter concludes with observations on the practical challenges that Malawi's intractable circumstances and critical HIV/AIDS response present making the case for a traditional rather than emergent aid architecture and donor/recipient relationship. The policy literatures related to aid and specific to Malawi are drawn on in this chapter to fill in the space between the 'high politics' of international institutions and their governance reflected in the IR literature and the institutional, policy and financial reality in Malawi.

## **2. Intractable Circumstances**

### Nascent Democracy

Malawi is a formative democracy with a political legacy of colonialism and totalitarianism. In 1891, Malawi was known as the Nyasaland and District Protectorate and claimed as a territory by the British. As Nyasaland, it was granted self-government by the British in 1963 and Dr. Hastings Kamuzu Banda was appointed Prime Minister, beginning over 30 years of autocratic rule. In 1964, Dr. Kamuzu Banda became President of the Republic of Malawi and by 1966 he had constitutionally established Malawi as a one-party state. In 1971 he became President for Life. Human Rights Watch (Human Rights Watch 1990, 'Malawi') described Malawi as a

...totalitarian state where independent associations and free expression - indeed all the manifestations of independent civil society - are effectively forbidden. It is at the same time a personal despotism in which the state apparatus is directly answerable to one man. Although many states in sub-Saharan Africa suffer from greater political violence than Malawi, there are few African countries with such a combination of totalitarianism and personal despotism.

Emancipation from colonial rule in the early 1960s marked the beginning of three decades of repressive government shaped by the authority of one man.

A series of events in the early 1990s led to Malawi's first multi-party elections in 1994. In 1992, the country's Catholic bishops authored a Lenten Pastoral Letter which was read in the country's Catholic Churches which condemned Malawi's political and human rights situation (Thompson 2005, p. 575) and later that year, a number of donors suspended aid (van Donge 1995, p. 231). Pressure from religious leaders and the international

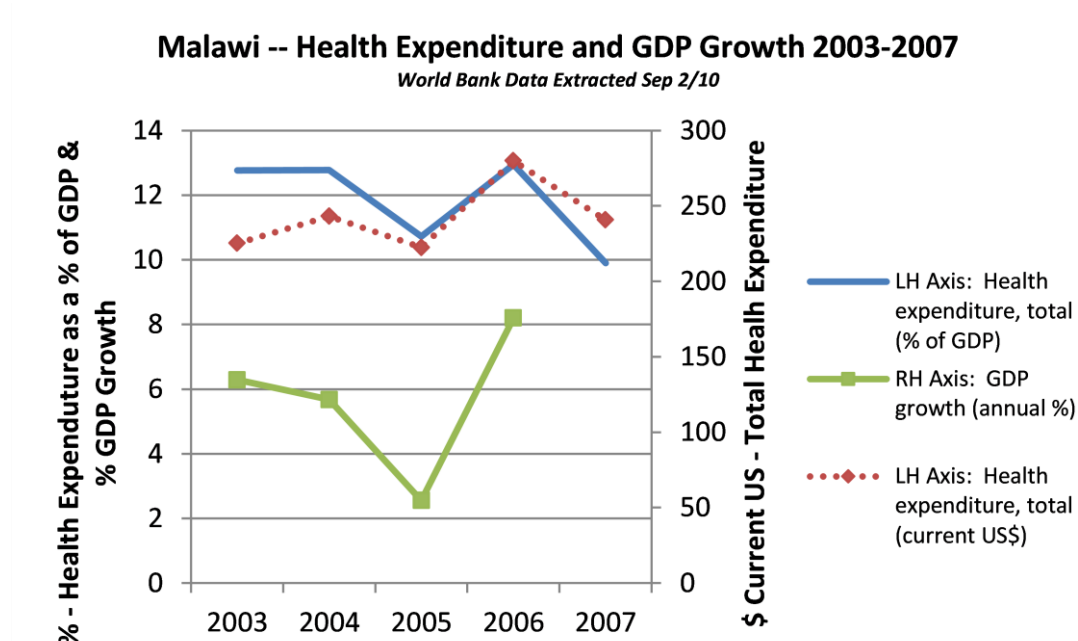
community was brought to bear on Banda who was experiencing failing health (van Donge 1995, p. 234) and in 1993 he was persuaded to hold a referendum on the one party state which Malawians rejected. As a consequence, the Republic held its first multi-party election the following year. Dr. Bakili Muluzi, leader of the opposition United Democratic Front (UDF) and a former cabinet minister under Banda won the election and served the constitutional limit of two terms as President. In 2004, Dr. Bingu wa Mutharika,<sup>17</sup> also from the UDF party was elected with a promise to clean up corruption. Donors and the IMF had again suspended support to Malawi in 2002 due to financial mismanagement and overspending (Ford 2004, p. 57) and Muluzi was eventually arrested on fraud and corruption charges in 2006. Mutharika broke with the UDF in 2005 and formed the Democratic Progressive Party (DPP) and was re-elected in 2009. Malawi's short experience with democracy has been tumultuous and the exercising of independent and accountable government, distinct from party politics and divorced from a history of corruption and repression, is far from secure.<sup>18</sup>

### Agricultural Economy

Malawi remains an underdeveloped agricultural economy despite its bold long-term vision. Vision 2020 was developed over a two year process<sup>19</sup> from 1996 to 1998 and lays out an ambitious 20 year trajectory: "By the year 2020, Malawi as a God-fearing nation will be secure, democratically mature, environmentally sustainable, self-reliant with equal opportunities for and active participation by all, having social services, vibrant cultural and religious values and being a technologically driven middle-income economy" (Government of Malawi 1997, 'Malawi Vision 2020 Mission Statement'). Progress has been slow. 52% of Malawi's population are poor and one in five people are ultra-poor, meaning they cannot afford to meet the minimum standard for daily-recommended food

requirements (Government of Malawi National Statistical Office 2005, p. 139). 80% of Malawi's workforce is employed in the agricultural sector which contributes over 80% of Malawi's foreign exchange earnings (Government of Malawi 2007, p. xv). Its main exports are tobacco, tea and sugar and its balance of trade has declined consistently from MK -1,401 mm (or US- \$314.30 mm) in 1994 and reaching MK -65,981 mm (US -\$477.24 mm) in 2008 (Government of Malawi Reserve Bank of Malawi (no date)).<sup>20</sup> Agriculture in Malawi is characterised by "low and stagnant yields, over dependence on rain-fed farming which increases vulnerability to weather related shocks, low level of irrigation development, and low uptake of improved farm inputs" (Government of Malawi 2007, p. xv).

**Figure 6: Malawi's Health Expenditure and GDP Growth - 2003-2007**



A drought that affected Malawi in 2005 exemplifies its vulnerability to external shocks and in turn how health expenditure is affected. Malawi's GDP growth was interrupted because it was necessary to import maize, a food staple, to prevent starvation and malnutrition (Government of Malawi Ministry of Economic Planning and Development 2005, p. 1). As

Figure 6 shows, the budget spent on importing maize resulted in reduced expenditures on health with both total health expenditure and health expenditure as a percentage of GDP declining in 2005.

Not only does the weakness in Malawi's economic structure expose its population to the risk of food insecurity it also exacerbates its vulnerability by compromising the resources available for other sectors such as health. As long as Malawi remains an importing, agricultural economy, economic development will be at the effect of conditions outside of its control and social development, such as improving health services, will falter as resources are focused on pressing food security needs.

#### Managed but Precarious Debt Exposure

Malawi has reduced its exposure to external debt, but its circumstances remain precarious. In 2006, Malawi received external debt relief through the Heavily Indebted Poor Countries Initiative (HIPC) and the Multilateral Debt Relief Initiative (MDRI). Its external debt was reduced from 136% of nominal GDP in 2005 (IMF 2006, p. 64) and in 2007 was 17% of GDP, projected to rise to 20% by 2009 (Government of Malawi Ministry of Finance 2009, p. 20), well within sustainable thresholds. Domestic debt has proven to be more problematic. The ratio of domestic debt stock to GDP was 19.8% in 2009, just below the sustainability threshold of 20% (Government of Malawi Ministry of Finance 2010, p. 29). Malawi's domestic debt has in the past been attributed to poor financial management and more recently to delays in the release of donor funds which require Malawi to borrow to finance public spending primarily through treasury bills with short-term maturities (Government of Malawi Ministry of Finance 2009, p. 27). While Malawi's overall debt picture is stable, it is vulnerable to shocks and analysis by the Government of Malawi indicates that "non-concessional financing and low GDP and exports growth could lead to



a steady increase in the debt ratios and thus breach the external debt sustainability thresholds by 2014” (Government of Malawi Ministry of Finance 2010, p. 28).

### Burgeoning Population

The projected rate of growth of Malawi’s population has serious implications for the cost to and the capacity of the Government of Malawi to provide food security, deliver social services such as primary education and essential health services, and facilitate GDP growth and employment opportunities. If population growth continues at its current rate, which considers mortality from HIV/AIDS, Malawi’s population is expected to grow to 40.5 million by 2040 (Government of Malawi Ministry of Development Planning and Cooperation 2010, p. 5). Should the total fertility rate reduce from its current level of six live births per woman to three live births per woman, the population by 2040, considering HIV/AIDS mortality, would be 30.7 million or almost 25% smaller (Government of Malawi Ministry of Development Planning and Cooperation 2010, p. 5).

More people, even when moderated, means increased demand for resources and services. This has implications for Malawi’s economic and social development and its ability move towards its vision of being a “technology driven, middle-income economy.” Consider the example of human health resources: in 2007, Malawi had 4,450 trained nurses, and approximately 3,000 midwives, or approximately one nurse or midwife for every 1,800 people. If the population continues to grow at its current rate, just over 22,500 additional nurses or midwives would be required just to sustain this already inadequate ratio (Government of Malawi Ministry of Development Planning and Cooperation 2010, p. 14). The rate of growth of Malawi’s population, even if it is moderated and even if innovative approaches to service delivery can be found, is a crucial consideration for policy and planning and threatens to undermine economic and social development.

### A Devastating HIV/AIDS Epidemic

Malawi has the ninth highest HIV/AIDS prevalence rate in the world (UNAIDS 2008, 'Adult (15-49) HIV prevalence per cent by country, 1990-2007') which has profound short and long term economic, social and psychological implications for the envisioned development of the country and the well-being of its population. The first HIV/AIDS case was diagnosed in Malawi in 1985 and prevalence at that time was estimated at 2% (Government of Malawi 2004, p. foreword). By 1995, HIV prevalence in antenatal women was estimated at over 30% in urban areas, HIV/AIDS was the leading cause of death in the most productive age group (20-48 years) and it accounted for over 40% of all in-patient admissions (Government of Malawi no date; p. 4). The number of people infected continued to grow. In 1987 there were 52,251 people living with HIV/AIDS. By 2003 there were 760,000 adult Malawians aged 15-49 years living with HIV/AIDS, 58% of whom were women; moreover, 900,000 Malawians were estimated to be HIV infected, including 70,000 children under the age of 14 (Kamanga 2006, p. 2).

As is the nature of HIV/AIDS the biomedical and social features of Malawi's epidemic are closely linked. Malawi's epidemic primarily spreads through heterosexual intercourse among couples in stable and in discordant relationships. More often it is women and adolescent girls who are infected making prevention of mother to child transmission an important element of the biomedical response (UNAIDS 2009, p. 1) and increasing the numbers of orphans and children living in child-headed households. As in virtually every other part of the world, reducing prevalence and incidence of HIV/AIDS is not just a medical undertaking. It requires changes to cultural and sexual practices. While Malawi has made gains in reducing prevalence and increasing access to treatment, its incidence rate remains between 1.2% and 1.6% (Government of Malawi Office of the President and

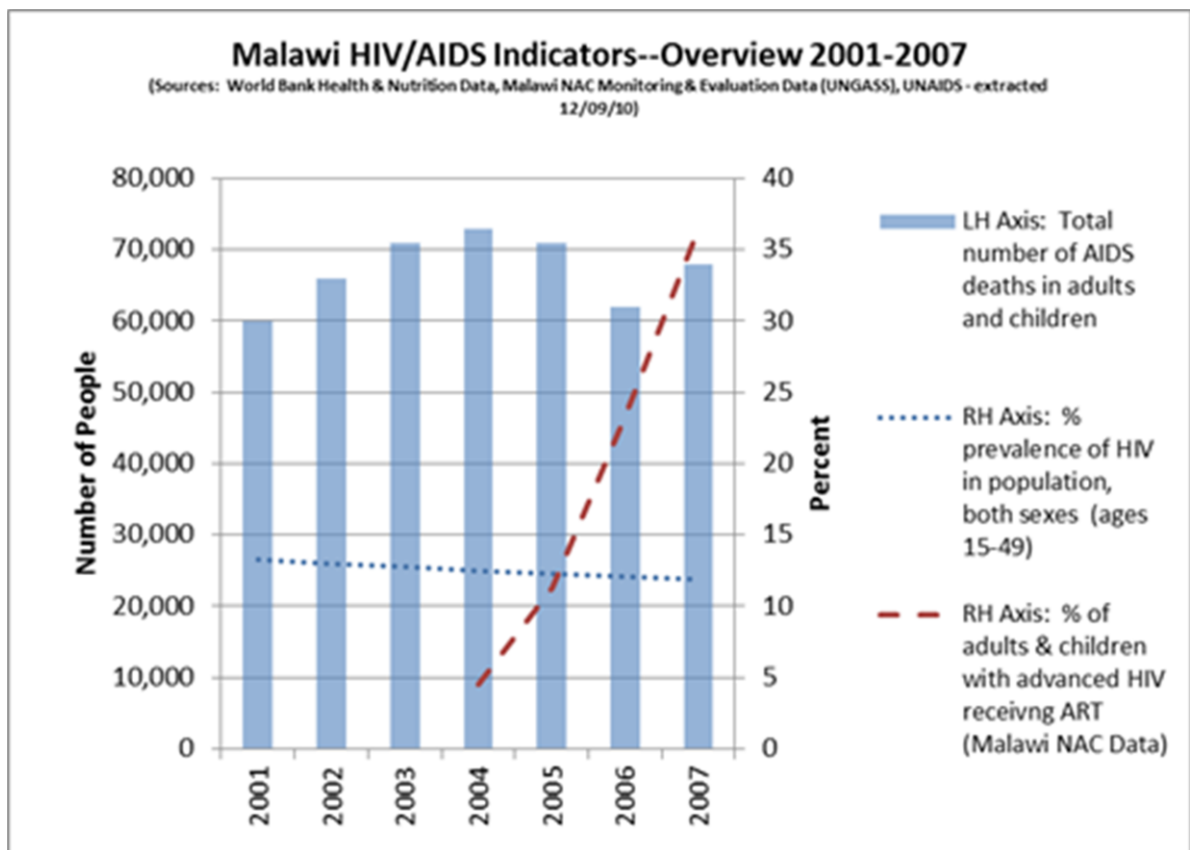
Cabinet 2009, p. 11) meaning the number of new infections continues to increase. As in other countries particularly low income countries in Sub-Saharan Africa where substantial proportions of the economically productive population are affected by the epidemic, Malawi risks a “hollowing out of state structures” (Poku and Whiteside 2006, p. 253). Malawi’s epidemic, where HIV/AIDS is spread through sexual transmission, women and girls are particularly vulnerable and reducing incidence will require changes to sexual and cultural practices. This makes evident why UNAIDS (2010e, p. 5) claims that “in virtually every country where marked progress in preventing new infections has been documented, a combination structural, behavioural and biomedical prevention approach has been used.”

In the early years of the epidemic in Malawi, the public health response focused on information, education and communication to reduce transmission, blood screening and collecting epidemiological data. The high cost of drugs, which were available and proven effective in developed countries, made treatment inaccessible for developing countries like Malawi. However, early in the 2000s, several events which pitted the interests of public health supported by vocal CSO and NGO communities against those of patent holding pharmaceutical manufacturers contributed to a dramatic decline in the cost of first line anti-retrovirals. These events included a declaration in 2001 on the Trade Related Aspects of Intellectual Property (TRIPS) at the Fourth Ministerial Conference of the World Trade Organization (WTO) in Doha which acknowledged the role of patent protection but supported members’ rights to protect public health and provide access to essential medicines (‘t Hoen 2003, p. 53); a failed legal challenge in 2001 by multi-national pharmaceutical manufacturers against the South African government for enacting a legal framework that provided for the generic substitution of off-patent medicines, transparent pricing for all medicines, and the parallel importation of patented medicines (‘t Hoen 2003, p. 43); the withdrawal of a WTO challenge by the United States against Brazil for Brazil’s

patent law which provided for compulsory licensing to manufacture drugs locally without the permission of the patent holder ('t Hoen 2003, p. 45); and also in 2001, the offer by Cipla, an Indian generic manufacturer, to sell a triple therapy combination anti-retroviral for US\$350 per patient year to Médecins sans Frontières if it was provided to patients for free and for US\$600 per patient year to governments. At the time multi-national manufacturers offered the same drug therapy for US\$3,617 (MSF 2001, 'NGOs denounce the lack of transparency in multi-national/UNAIDS anti-retroviral drug deal for Kenya'). The hold on anti-retroviral therapy drug prices by patent owning multinational pharmaceutical companies had been broken and poor countries and their affected populations now had a better chance of accessing life-saving treatment.

By 2004, the pressure brought to bear on the price of anti-retroviral drugs coupled with the availability of funds to purchase them from the Global Fund and later from PEPFAR made the scale up of treatment programmes possible, and this was the case in Malawi. Despite the magnitude of its epidemic, Malawi made gains in its response as Figure 7 shows, dramatically scaling up the number of people on anti-retroviral therapy by 2009 to almost two thirds of adults and children in advanced stages of AIDS (Government of Malawi Office of the President and Cabinet 2010, p. 202 ) and reducing the overall HIV/AIDS prevalence in the adult population from 14.6% in 2000 to just under an estimated 12% by 2007 (World Bank 2010, Health Nutrition and Population Statistics). 20 years after the first case of HIV/AIDS was reported in Malawi, just over 11% of adults and children with advanced HIV/AIDS were receiving anti-retroviral therapy (Government of Malawi Office of the President and Cabinet 2010, p. 202). Over the following years, this number continued its dramatic increase challenging if not abating the devastating economic, social and psychological impact of the epidemic.

Figure 7: Malawi - Select HIV/AIDS Indicators 2001-2007



#### An Initial, Imperfect Policy Response

The Strategic Planning Unit in the National AIDS Control Programme in Malawi's Ministry of Health began development of the first strategic framework to address HIV/AIDS in the late 1990s (Government of Malawi 2004, p. 6) creating the *National Strategic Framework for HIV/AIDS: 2000-2004*. At that time there was recognition that despite efforts by government and donors "...there has not been much improvement in the HIV/AIDS situation. The incidence of HIV infection has continued to be high especially in adolescent females, the levels of stigmatization have continued to be high and there are inadequate care and social support services for people living with HIV/AIDS" (Government of Malawi 2000, p. 2). The first strategic framework focused on reducing transmission, reducing impact at the individual, community and national levels and special programmes aimed at youth, values and culture, media and widows and widowers.

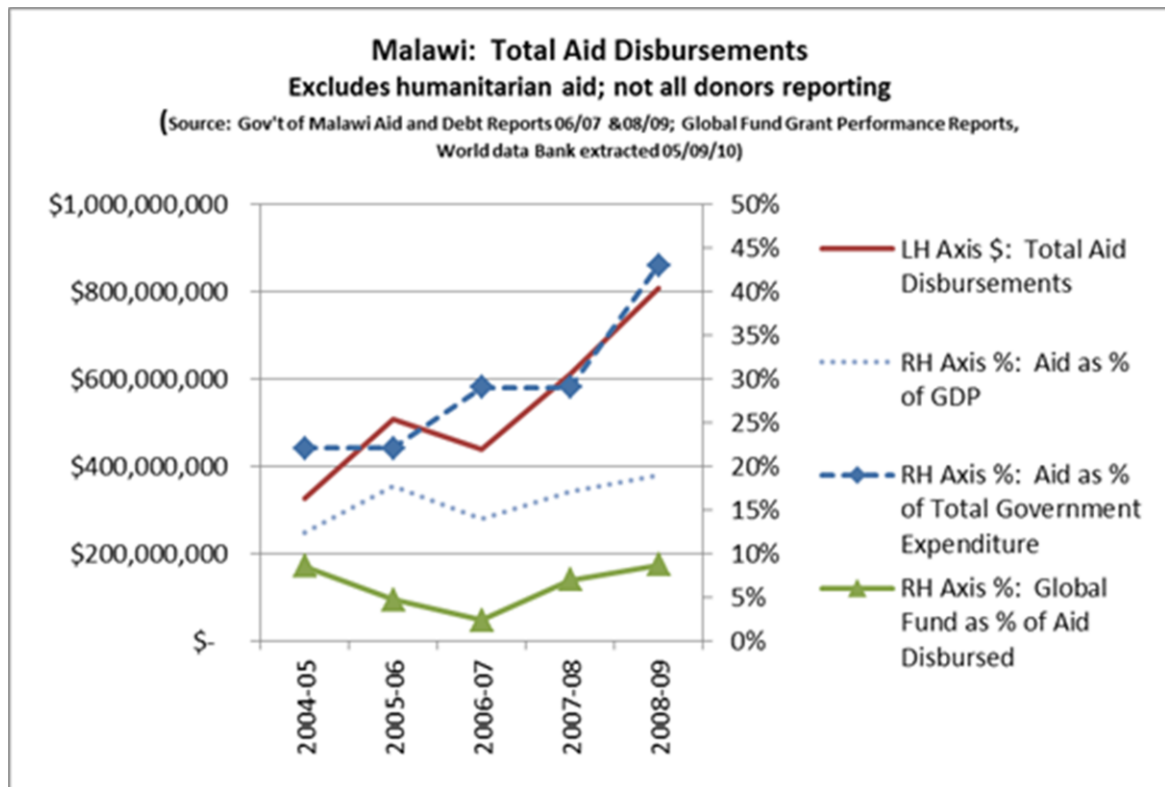
“Reducing impact” included anti-retroviral treatment but it was not a priority because of the prohibitive cost of drugs at the time. “The response of the affluent countries and their institutions—from aid agencies, non-governmental organisations, and the pharmaceutical industry—has been insufficient...[it] has consisted of the promotion of education and condom distribution to prevent HIV transmission” (Farmer et al 2001, p. 404). Malawi’s early HIV/AIDS strategy reflected this reality.

#### Aid Reliance and New Sources of Aid

As Figure 8 indicates, Malawi is highly dependent on aid and this dependency shows no signs of abating. In 2004/05, aid comprised 22% of government expenditure and this rose to 43% by 2008/09 (Government of Malawi Ministry of Finance 2009, p. 18). While Malawi characterises this rise as an indication of donor confidence in the Government’s ability to manage aid effectively (Government of Malawi Ministry of Finance 2009, p. 18), it is also indicative of a weak economic structure and an inadequate tax base to support public expenditure.

Aid to Malawi reflects donors’ response to the country’s HIV/AIDS crisis as much as donors’ interests in the promotion of economic growth. In 2008/09 Malawi’s health sector received almost 32% of total donor support provided to the country, more than any other sector. The Global Fund, which focuses on three diseases, was the third largest donor overall providing 14.6% of all aid after the EU at 18.1% and DfID at 14.7% (Government of Malawi Ministry of Finance 2009, p. 5). Given its weak economic foundation and inadequate tax base, Malawi’s spending on health and its response to its HIV/AIDS epidemic will remain reliant on donor support and in particular that of the Global Fund.

**Figure 8: Malawi - Aid Disbursements 2005-2009**



Aid to Malawi provides evidence of a changing landscape particularly for HIV/AIDS endemic countries: the overall amount of aid has increased significantly, there is a proliferation of donors and bilateral aid providers and the Global Fund, a new type of aid provider, plays a significant and influential role (Bonnell 2009, p. 162; Lele, Sadik and Simmons no date, p. 1). While some argue that these changes are signs of a new, emerging aid architecture which promotes ‘country ownership’ (a concept discussed in Chapter 5) and results-based funding (Bourguignon and Sundberg 2007, p. 319; Bonnell 2009, p. 165), others argue that the gap between donor intention and reality remains significant (Christiansen and Rogerson, 2005, p. 1; Birdsall 2007, p. 593). As will be discussed in the following sections, while Malawi benefits from and achieves results with its aid for HIV/AIDS, this aid comes with the challenge of managing a highly fragmented donor landscape (Government of Malawi Ministry of Finance 2009, p. 15) and the politics and practicalities of institutional complexity. In other words Malawi’s response to its HIV/AIDS epidemic provides evidence of the gap between the “ambitions and rhetoric

about broad donor reform...and the reality of how donors actually behave” (Birdsall 2007, p. 593).

Malawi faces an array of intractable circumstances including a short and tumultuous democratic history following a long period of totalitarian rule, food insecurity risks associated with its weak agricultural economy, its managed but precarious exposure to debt, and its burgeoning population all of which exacerbate its ability to respond to a devastating HIV/AIDS epidemic. Donors have responded to Malawi’s circumstances by dramatically increasing aid over a relatively short period and entrenching its aid reliance. One result has been significant progress in Malawi’s scaled up response to its HIV/AIDS epidemic which includes providing access to anti-retroviral therapy to over 300,000 adults and children in the advanced stages of the disease and reducing the overall prevalence rate in the population to just under 12%. The next section will describe the health sector in more detail including the participation of and funding by development partners that have formed and informed Malawi’s HIV/AIDS response.

### **3. Malawi’s Health Sector: Evidence of an Emergent Aid Architecture?**

Towards the end of the 1990s and into the early years of the 2000s, Malawi put in place a governance, policy and financing architecture that would support its scale up of its HIV/AIDS response. This section describes the health sector overall, including its planning, oversight and funding frameworks, its financing particularly the level of contribution of donors, and finally the broader context in which Malawi’s HIV/AIDS response is situated. It provides a picture of how donors have shaped Malawi’s health programme, both mechanistically through instituting a Sector Wide Approach (SWAp) and then by significantly growing donor contributions through the SWAp. What emerges is a picture of a rise in donor funding accompanied by a decline in government support, an



ambitious implementation agenda and an intensification of institutions, interests and politics associated with governing resources and policy. The question remains whether this constitutes an emerging aid architecture or if it is more akin to the power dynamics in the traditional donor/recipient relationships ‘of old’.

### Governing Malawi’s Programme of Work and the Health SWAp

The Ministry of Health and Population (MoHP) leads policy development for health which has been most recently guided by the Programme of Work for 2004-2010. While planning appears to be well coordinated, the funding, implementation and oversight of the Programme of Work is complex, involving facilitating and overseeing a range of internal, donor and NGO relationships. The Programme of Work includes the Essential Health Package which “...refers to a prioritised but limited package of services that should be available to every individual in Malawi. It comprises eleven key components...and these cover those health services that address the major causes of death and disease in Malawi, together with the essential supporting structures and systems to enable delivery” (Government of Malawi Ministry of Health Department of Planning 2004, p. 1). The Programme of Work determines ‘what’ comprises the Essential Health Package. The SWAp provides the ‘how’, the funding and management for the Programme of Work.

The Health SWAp was adopted to provide “a single health strategic framework, a common expenditure framework, a common monitoring framework and better coordinated procedures for funding and procurement. The purpose of bringing in a sector-wide approach is to “improve the harmonisation of different actors’ interventions...and to increase alignment with government policies and procedures” (Carlson et al. 2008a, p. 63). In Malawi, despite the SWAp mechanism, institutional and political complexity remains.

There are a number of governance fora and mechanisms for managing the Health SWAp in Malawi and delivering the Essential Health Package services. For example, donors have Memoranda of Understanding with the government and participate in formal Health SWAp governance groups including the Health Sector Review Group with government. NGO and private sector providers, and in some cases donors may also provide advice through their participation in Technical Working Groups which provide advice to higher level fora. In addition, donors have a Health Donor Group which while not part of the formal Health SWAp governance structure does inform it and is attended by the MoHP. A mid-term review of the Health SWAp acknowledged the importance of having a Programme of Work with an Essential Health Package facilitated by a SWAp (Carlson et al. 2008a, p. 62) but also noted the challenges that come with managing its oversight and implementation in a complex, resource constrained environment:

...there is a sense of crisis and uncertainty about the future of the [Health] SWAp. This being the case, there is a need for urgent attention to resolve...challenges and to put the SWAp partnership and programme back on track.... This will require the MOH [Ministry of Health and Population] committing itself to ensuring that the agreed to governance committees and procedures are adhered to, and development partners holding each other and government to their commitments as detailed in the MOU [Memorandum of Understanding] and in international agreements (Carlson et al. 2008b, p. 268).

Two years after this mid-term review, interviews for this research did not reveal the same sense of urgency to strengthen the Health SWAp and donors and ministry staff were engaged in negotiating its successor; nevertheless, the findings of the mid-term review do show that while the MoHP might lead and own strategy development, governing the strategy and realising its implementation requires successfully managing the alignment and

commitment of a range of partners and interests across several donor and government fora over a sustained period.

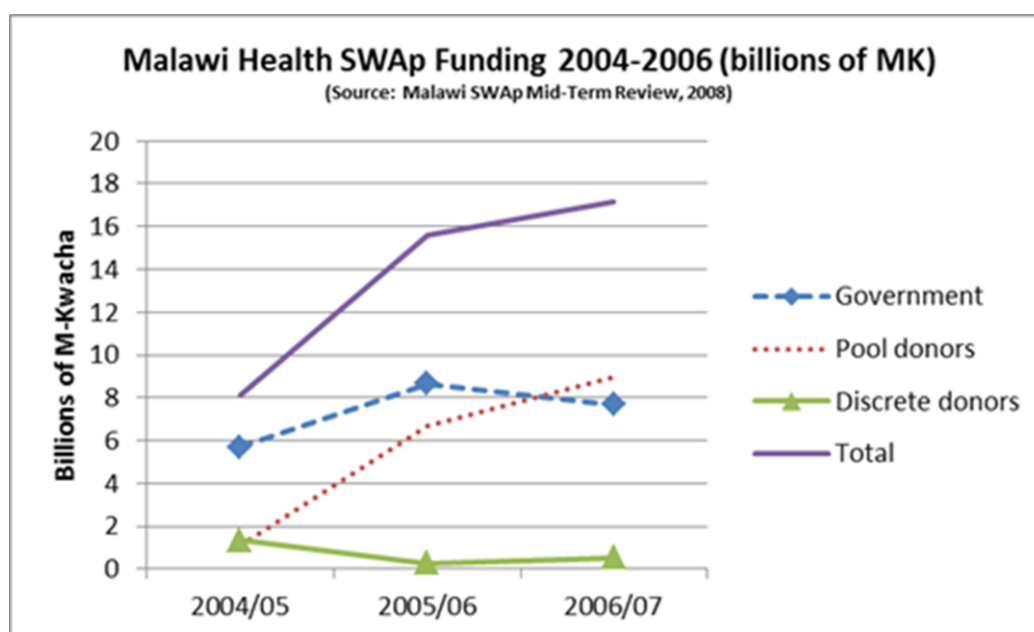
### Declining Government and Increased Donor Financing for Health

Although the Government of Malawi provides funding for health and in particular the Health SWAp, resources largely come from donors. Since 2002, overall support to the health sector has increased; however, the proportion contributed by government to the total health expenditure—which includes public and private expenditure—has been declining. An analysis of Malawi's National Health Accounts for 2002 to 2004 showed that while per capita expenditure on health rose from US\$15 in 2002/03 to US\$20 in 2004/05, the government's contribution to the Total Health Expenditure in this period declined from 35% to 25%, donor support increased from 45% to 60% and households on average contributed 10.3% (Government of Malawi Ministry of Health 2007, p. xviii). The Programme of Work was costed at US\$735 mm or US\$17 per capita which was later revised to US\$22 when overhead and other costs were factored in (Carlson et al. 2008b, p. 25 and p.227). In 2006/07, per capita funding for the Essential Health Package was estimated at US\$10 (Government of Malawi Ministry of Finance 2007, p. 108)<sup>21</sup> which excluded funding received by the National AIDS Commission (NAC) for its HIV/AIDS strategy and the NAC Programme of Work, which in the same year amounted to approximately US\$1.15 per capita (African Development Bank 2009, p. 7).<sup>22</sup> Taken together, this per capita funding of the overall Programme of Work is not only significantly less than the estimate of US\$22 per capita to provide Malawi's Essential Health Package but also much less than the US\$34 per capita required to provide essential health services estimated by the Report of the Commission on Macroeconomics and Health in 2001 (WHO 2001a, p. 11). While the Essential Health Package is likely to remain

‘underfunded’ relative to its initial costing, it’s important to keep in mind that donor resources for health contributed to Malawi are considerable and reflective of a consistent increase in Official Development Assistance resources and Development Assistance for Health since the new millennium (African Development Bank 2009, p. 2; Ravishankar et al. 2009, p. 2113). While more can be understood to be good, more is only good when capacity exists in the system to absorb these resources (Carlson et al. 2008b, p. 220) and govern them to achieve better health outcomes for Malawians.

Conceptually, the Health SWAp is intended to reduce donor transaction costs by applying a pool of funds to an agreed upon Programme of Work. In practice, the mode of donor support does not always align with this intent. First of all, there are two types of donors: pool donors as well as donors who contribute outside of the pool. Contributions to Malawi’s Health SWAp include pooled funds provided by donors such as DfID, the Government of Norway, and UNFPA; pooled funds with conditions and restrictions provided by donors such as the World Bank and the Global Fund; and discrete support from donors such as USAID and AfDB (Carlson et al. 2008a, p. 57). Second, the proportion contributed by pool donors, as Figure 9 shows, is increasing. The proportion of funding to the Health SWAp provided by the government has declined from 2004/05 from 70% to 45% while the contribution by pool donors has increased from 14% to 52% (Carlson et al. 2008b, p. 220).

**Figure 9: Malawi's Health SWAp Funding - 2004-2006**



Lastly, donor support for the Health SWAp is significant compared to other sectors and within the Health SWAp the Global Fund contributes a large proportion. In 2008/09 11% of all donor support to Malawi across all sectors went to the Health SWAp (Government of Malawi Ministry of Finance 2009, p. 9). In this same period the Global Fund made the largest contribution to the Health SWAp providing 39% of all donor funds. The Global Fund's 'pooled' support was for interventions related to health systems strengthening, malaria and tuberculosis (its support for HIV/AIDS is largely accounted for through the NAC's SWAp). The Health SWAp mid-term review described the Global Fund's contribution akin to that of a bilateral donor:

...being 'in' the pool, but not 'of' the pool. Global Fund planning cycles are separate to those of the MOH [Ministry of Health and Population], and resemble more the bilateral planning exercises undertaken by USAID or ADB [referring to the African Development Bank], albeit at least with more MOH and other donor participation than is the case with either ADB or USAID. The Global Fund also sets 'conditions precedent' bilaterally with the MOH without discussion with other

health donors. Finally, in order to monitor progress towards meeting these conditions precedent (as well as to set further ones) the Global Fund/LFA [Local Fund Agent] may initiate their own assessment processes. The results of these assessments may not be communicated to either government or other health donors, except to say whether the conditions are deemed to have been met and funds can be disbursed, or that conditions have not been met (or new conditions are to be imposed) and therefore funds cannot be disbursed (Carlson et al. 2008b, p. 258).

The nature of the Global Fund's programmatic and performance based funding model does not fit easily with the concept of pooled funding for a Health SWAp and the practical nature of allocating resources and attributing results to deliver an Essential Health Package with broader reach than the Global Fund's disease and health systems strengthening focus:

One of the things [the Global Fund wants to look at is] how participating in a pooled fund [the Health SWAp] works because the Global Fund still wants to count its beans. That is an issue of contention and tension between the Global Fund and the rest of the donors because ...the money loses its colour, but the Global Fund wants to say, "where did my dollar go?" for their reporting requirements (International CCM Member 2010, interview, Lilongwe).

The Global Fund's support for Malawi's Health SWAp is crucial and given its relative magnitude, influential; however, the nature of its participation in the Health SWAp is a good example of the collision between setting and measuring health outcomes through vertical programming and the efficiencies for recipient countries that a 'pooled' Health SWAp approach is intended to provide. From the perspective of the overall health sector, it's unclear whether the aid architecture that Bourguignon and Sundberg (2007, p. 319)

envisioned is in fact emerging in Malawi. There is an argument to be made for donor alignment around a health strategy and the notion that donor support is based on performance; however, the extent to which the agenda is owned by the country or directed by influential donors like the Global Fund remains open.

#### **4. A Scaled Up HIV/AIDS Response and an Elusive Aid Architecture**

##### A Strategic Approach and a Successful Response

A lot changed from Malawi's 'imperfect' policy response in the early years of the HIV/AIDS epidemic by the time the National HIV/AIDS Action Framework (NAF) for 2005-2009 was developed. The country's HIV/AIDS response was situated in a larger, multi-sectoral context through the 2002 Poverty Reduction Strategy (PRSP) which identified HIV/AIDS as a cross-cutting theme and promoted decentralisation of government services more broadly in order to foster the "...empowerment of the people for effective popular participation and decision making in the development process in their respective areas" (Government of Malawi 2002, p. xv). Malawi established a National AIDS Commission (NAC) in 2001 to coordinate leadership of the country's response to the epidemic and the NAC developed the country's first HIV/AIDS policy in 2003 as well as a monitoring and evaluation approach, making it a focal point for 'the three ones': one national HIV/AIDS coordinating authority, one national HIV/AIDS action framework, and one monitoring and evaluation framework. Malawi developed policies for Orphans and Other Vulnerable Children, an Anti-retroviral Equity Policy and guidelines for Anti-retroviral and Voluntary Counselling and Testing (Government of Malawi 2004, p. xi). In addition, Malawi received its first Global Fund resources in the 2003/04 year from its successful Round 1 grant application for HIV/AIDS which allowed it to take advantage of the reduced costs of anti-retroviral therapy and plan for scaled up treatment. Finally, in

2004, the MoHP developed its Programme of Work to deliver the Essential Health Package and established the Health SWAp to fund service delivery to a decentralising health system. The goal of decentralisation was to make health planning responsive to local needs, allow resources in the Essential Health Package including scarce human resources to be allocated according to need and to alleviate pressure on primary care delivery by helping to strengthen rural service delivery infrastructure (Government of Malawi 2002, p. 62). The HIV/AIDS response was situated within the context of the PRSP which provided the macro economic framework for the country, and was defined through specific HIV/AIDS policies and plans within an overall plan for the health sector. The adoption of decentralisation and the extent of the macroeconomic contextualisation reflected both the devastating nature of the epidemic, and the magnitude of the effort required to address it.

Malawi scaled up its response to HIV/AIDS in a short period of time and exceeded the initial targets it set. This section discusses how Malawi did so in an environment of institutional complexity, which included the newly created NAC, the national coordinating body, and a range of implementing stakeholders at national, district and community levels. It will also describe challenges including that of absorption of significant new resources, the capacity to scale quickly enough to allocate them and implement programmes, and the tension between persistent need and uncertainties associated with Global Fund grants.

In the early 2000s, despite the progress made in Malawi, there was little impact on the overall epidemic. In 2003, the HIV/AIDS prevalence rate remained virtually unchanged at an estimated 14.4% compared to 14.6% in 2000 (Government of Malawi 2004, p. xi). The first NAF for 2005-2009 had to be an effective strategic framework with social and biomedical outcomes and one that supported a scaled up response. The 2005-2009 NAF



focused on prevention, treatment and reducing the socio-economic and psychosocial impact of the epidemic and on the underlying capacity, research, monitoring and evaluation, resource mobilisation and policy and planning that would be necessary to effect change. Its goal was “[t]o prevent the spread of HIV infection among Malawians, provide access to treatment for PLWHA [People Living with HIV/AIDS] and mitigate the health, socio-economic and psychosocial impact of HIV/AIDS on individuals, families, communities and the nation” (Government of Malawi 2004, p. 16). Its targets included: reducing HIV/AIDS prevalence to from 14.2% in 2004 to 13.5% by 2009 (Government of Malawi 2004, Annex 1-p. 1); increasing the number of people testing for and receiving their serostatus results (which tests the presence or absence of antibodies in the blood) from 177,726 tested and 66,182 receiving their results in 2004 to 993,000 tested and 794,400 receiving their results in 2009 (Government of Malawi 2004, Annex 1-p. 7); and increasing the number of people with advanced HIV receiving anti-retroviral therapy from 13,183 in 2004 to 80,000 in 2009 (Government of Malawi 2004, Annex 1-p. 8). Against these initial estimates, some significant achievements were made in the implementation of the 2005-2009 NAF and the scale of the response to the epidemic (see Figure 7). By 2009, the HIV/AIDS prevalence rate had stabilised at 12%, 1.5% lower than targeted (Government of Malawi 2009, p. 8) and the number of people receiving anti-retroviral therapy was 147,000 (Government of Malawi 2009, p. 25), exceeding the initial target by 75%.

### Institutional Complexity

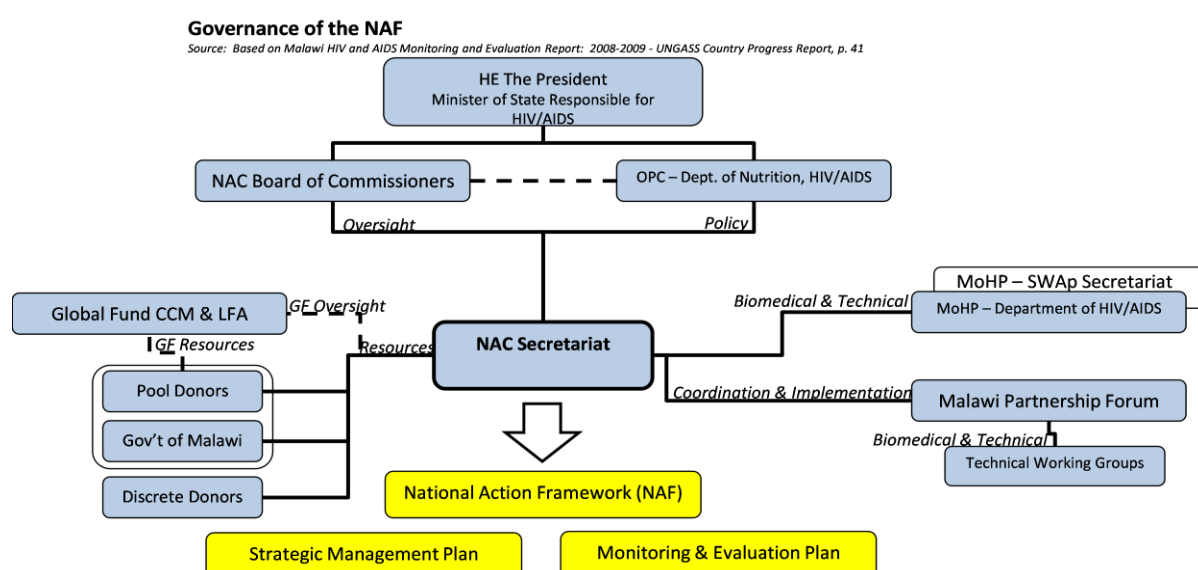
As Figure 10 indicates, implementing the 2005-2009 NAF took place in a complex institutional environment. At national level the primary organisations were the NAC, the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet (OPC),

and the MoHP. Roles and responsibilities among these organisations have not always been clear. The NAC is an independent trust with a Board of Commissioners appointed by the Minister responsible for HIV/AIDS in the OPC, currently the country's President (National AIDS Commission 2003, p. 6). The NAC leads and coordinates the country's HIV/AIDS response, but it is not an implementing agent itself. The NAC also serves as the Principal Recipient for Global Fund HIV/AIDS grants received by Malawi and, in what has been noted as a conflict of interest (Dickinson et al 2008, p. 34), has also chaired the Global Fund's CCM. Within the OPC lies the Department of Nutrition, HIV and AIDS which is responsible for "policy, oversight and high level advocacy" (Government of Malawi 2009, p. 13). The MoHP through the Department of HIV/AIDS provides "technical direction and service delivery in biomedical areas of prevention, treatment and care...which includes 1) Developing Policies and Guidelines on biomedical HIV and AIDS interventions; 2) Planning and implementing biomedical HIV and AIDS interventions; 3) Coordinating health sector thematic areas; 4) Providing technical support for HIV and AIDS policy development; 5) Providing technical support in implementation of health related HIV and AIDS interventions; and 6) Surveillance for HIV/AIDS/STI [Sexually Transmitted Infections]" (Government of Malawi Office of the President and Cabinet 2010, p. 44) .

Among the NAC, the OPC Department of Nutrition, HIV and AIDS and the MoHP, roles and responsibilities have required clarification as the country's HIV/AIDS response has evolved (Dickinson et al 2007, p.19):

...But the issue with that unit [Department of Nutrition, HIV and AIDS in the OPC] is capacity. There weren't that many HIV/AIDS experts in policy or health. Mary Shawa [Principal Secretary] is a nutritionist by training, not a health expert...NAC is just an implementer. It is not a policy setting body. So the issue there is coordination. There was a fight for a long time between the HIV/AIDS Unit [OPC] and the Ministry of Health. The Ministry of Health has an HIV/AIDS unit headed by a director. So you had two government departments both dealing with HIV/AIDS policy so there was a turf war for a while but now obviously you would say the OPC is in charge of policy setting (International CCM Member 2010, interview, Lilongwe).

**Figure 10: Institutional Governance of Malawi's National HIV/AIDS Framework**



What has emerged is an arrangement where the NAC coordinates the overall HIV/AIDS response including HIV/AIDS funding from the Global Fund and other donors. The Department of Nutrition, HIV and AIDS in the OPC has overall policy and high level advocacy ownership and the MoHP provides technical and biomedical leadership.

However, as will be discussed in relation to agenda setting in Chapter 5, the relations among the NAC, the Department of Nutrition, HIV and AIDS in the OPC and the MoHP has at times been fraught and remains dynamic. In particular, there was a recognised “...power play, particularly when it was Mwale [NAC] against Shawa [Department of Nutrition, HIV and AIDS in the OPC]” (International CCM Member 2010, interview, Lilongwe). Mwale was considered influential and a strong leader, but left NAC in 2010 for a post with UNAIDS. His successor, was considered upon his appointment as “...not a serious player in the country” (International CCM Member 2010, interview, Lilongwe). Also by 2010, the MoHP was seen as weak, lacking the leadership, vision, direction and accountability it exhibited in the early days of the HIV/AIDS scale up which was attributed to Professor Harries<sup>23</sup> who has since left his role (Government of Malawi/NAC Representative 2010, interview, Lilongwe). Adding to these interplays of personality and institutional politics was Malawi’s proposed HIV/AIDS legislation which among other things has recommended moving the NAC directly under the OPC, consolidating ownership and authority under Shawa and the President (International CCM Member 2010, interview, Lilongwe). Explanations for leadership and ownership of Malawi’s HIV/AIDS response which focuses on formal organisational roles belie the dynamic institutional competition that exists among national institutions and the personalities of their leaders. The agenda setting, policy making and oversight for a healthy proportion of the government’s budget lie in an elite institutional domain led by politically influential individuals.

Given the influx of resources and multiplicity of international and national agendas of the variety of organisations engaged in Malawi’s HIV/AIDS response, it would not be unreasonable to expect that institutional competition is also alive and well among others. These include government ministries such as the Ministry of Finance (MoF), the Ministry

of Economic Planning and Development, the Department of Human Resources Management and Development, the Law Commission and the Human Rights Commission. The Department of Nutrition, HIV and AIDS in the OPC works to 'mainstream' HIV/AIDS within line ministries and ministries are to commit 2% of their budgets to address HIV/AIDS (Dickinson et al 2008, p. 33; Government of Malawi/NAC Representative 2010, interview, Lilongwe). In addition to government and parastatal organisations, the international community through donors and NGOs exercises formal influence through mechanisms such as the Health SWAp, the NAC SWAp, or as members of the CCM which applies and provides oversight for Global Fund grants. There are many institutional interests and priorities at play, both among state and non-state and national and international actors when it comes to governing Malawi's HIV/AIDS response and the resources that come with it.

Because of Malawi's decentralisation of its health service planning and delivery, local authorities also play an important role in this aspect of the HIV/AIDS response by providing coordination at district and community levels. These include Community Based Organisations, Support Groups, Community AIDS Committees, District Development Committees, Area Development Committees and local NGOs (Government of Malawi 2009, p. 14). Faith based organisations and community based organisations are the primary implementing agencies and apply to the NAC for funds. They work at national, district and community levels to help communities advocate, plan, mobilise resources and develop capacity. The Malawi Business Coalition on AIDS has the responsibility to mainstream HIV/AIDS into workplace policies and programmes (Government of Malawi 2009, p. 14). Finally there are the associations for People Living with HIV/AIDS which work at national, district and community levels and through the CCM to advocate on behalf of people living with and affected by the disease. As expected from a decentralising

system, district and community based organisations are critical to coordinating and implementing the country's HIV/AIDS response.

In addition to the complex formal institutional structure there is a sphere of less formal activity comprised of national and international non-elite actors. As Swidler (2006, p. 279) remarks, perhaps cynically,

[i]t takes only a brief period on the ground in Malawi to run into groups of American church members who are travelling around the country looking for villages that need boreholes...dug, a group of international students doing a summer AIDS project in a village...So bureaucracy at the top often monitors a bevy of independent actors on the ground. Paperwork may flow both to the national and international offices of the NGO and to the government, describing the number of programmes underway each month or each quarter, the number of youth involved or homes visited and so forth, but the actual practices on the ground are closer to the patron-client arrangement in which what the clients provide their NGO patrons is evidence that the programme actually has participants, households or needy children that it serves.

Somewhat evocative of Boone and Batsell's thousand points of light, these individuals or organisations as Swidler points out in some cases feed up into more formal and elite institutional structures, but they are just as likely to have locally based relationships and operate outside of more formal governance mechanisms making their scope and influence difficult to assess and clearly reflect.

Within this complex, layered environment, the NAC operates the Malawi Partnership Forum which acts as the primary vehicle through which the NAC manages and coordinates planning and implementation. The Malawi Partnership Forum is informed by a series of

technical working groups which develop strategy, plan and oversee implementation and track outcomes. The NAC's coordination remit is no small task requiring attention to the division of labour among the primary leaders at national level, managing relationships with donors including through the CCM, as well as coordinating and overseeing a decentralised implementation landscape with diverse interests. This institutional diversity and complexity provides community level infrastructure to support implementation on a large scale. As discussed earlier in this chapter and as Figure 7 shows, Malawi has navigated the intensification of interests and institutional politics, and a complex institutional landscape including at local levels to scale up its HIV/AIDS response and achieve results.

#### Investment, Results but Continued Vulnerability

Like the health sector overall, funding of Malawi's HIV/AIDS response is reliant on donor support and predominantly that of the Global Fund. The 2009 Government of Malawi UNGASS Report identified four sources of funds for the national response:

First is through voted expenditure. The GoM [Government of Malawi] National Budget covers most of the basic infrastructure and human resources for implementation in the public sector response. Second, resources are pooled into the NAC Pool Fund, which is a harmonized pool of primarily donor funding which is allocated annually for implementation of the NAF through the Integrated Annual Work Plan (IAWP). Third, are resources from the Health SWAp Pool Fund...Finally there is direct funding to implementers from discrete donors or other funding sources...NAC is not accountable for... [this fourth source of] funds (Government of Malawi Office of the President and Cabinet 2010, p. 111).

The NAC is charged with resource mobilisation for the HIV/AIDS response. Like the Health SWAp, the NAC uses a pooled funding approach which includes the Government

of Malawi and the Governments of Norway and Sweden, DfID, CIDA, the World Bank, and as of 2006/07, the Global Fund. The AfDB, CDC, UNDP and JICA remain discrete funders. With the addition of the Global Fund to the pool in 2006/07, pool funders contributed approximately 98% of the NAC's development assistance (African Development Bank Group 2009, p. 7). The NAC, as the Principal Recipient for HIV/AIDS Global Fund grants, flows funds to the Health SWAp for MoHP implementation activities related to HIV/AIDS (Dickinson et al 2008, p. 33). The Global Fund is the largest single donor to Malawi's HIV/AIDS response and was projected to provide just over 40% of Malawi's HIV/AIDS funding in the 2010 to 2012 period with the United States' CDC providing just over 27% and the Ministry of Finance just over 1% (Government of Malawi Office of the President and Cabinet 2009, p. 53).<sup>24</sup>

Approximately 80% of all Global Fund disbursements to Malawi from 2003 until June 2010 were for HIV/AIDS related grants.<sup>25</sup> As Table 1 indicates, Malawi's Round 1 grant for HIV/AIDS had an initial Phase 1 budget of US\$41.74 mm. This grant was re-negotiated in 2008 subsequent to the completion of its second phase into what the Global Fund calls a Rolling Continuation Channel grant. The Global Fund introduced the Rolling Continuation Channel option in 2006 to extend high performing grants beyond their second phase to facilitate lower transaction costs, longer funding periods and greater predictability (The Global Fund 2006, p. 10). The Rolling Continuation Channel grant remains the main source of funding for Malawi's national HIV/AIDS response.

**Table 1: Summary of Malawi's Global Fund HIV/AIDS Grants Including Disbursements from 2003 to June 2010**

<b>Summary of Malawi's Global Fund HIV/AIDS Grants (US\$) (Source: Global Fund Grant Performance Reports)</b>					
<b>Round and Focus</b>	<b>Lifetime Budget</b>	<b>Phase 1</b>	<b>Phase 2</b>	<b>RCC</b>	<b>Total Disbursed as of June 2010</b>
<b>Round 1 &amp; Rolling</b>	\$544,233,360	\$41,751,500	\$136,862,764	\$163,943,331	\$136,176,829

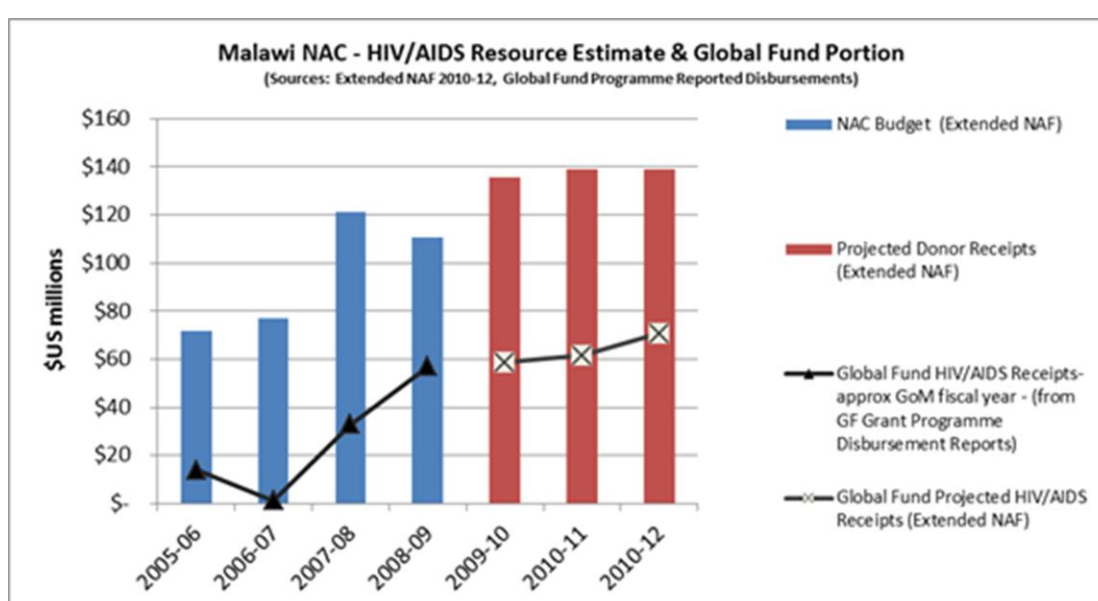


<b>Summary of Malawi's Global Fund HIV/AIDS Grants (US\$) (Source: Global Fund Grant Performance Reports)</b>					
<b>Round and Focus</b>	<b>Lifetime Budget</b>	<b>Phase 1</b>	<b>Phase 2</b>	<b>RCC</b>	<b>Total Disbursed as of June 2010</b>
<b>Continuation Channel – HIV/AIDS</b>					
<b>Round 5 – Orphans and Other Vulnerable Children (Orphans and Other Vulnerable Children)</b>	\$17,589,438	\$7,708,331	\$9,881,107		\$16,105,063
<b>Round 7 – Behaviour Change and Communication (BCC)</b>	\$36,025,380	\$15,078,417	-		\$13,258,014
<b>Totals</b>	<b>\$597,848,178</b>	<b>\$64,538,248</b>	<b>\$146,743,871</b>		<b>\$165,539,906</b>

Both the 2005-2009 NAF and the extended NAF for 2010-2012 are costed significantly above the resource estimates to fund the plans but this is not the whole story. For example, the 2005-2009 NAF was costed at US\$619.65 mm (Government of Malawi 2004, Annex 1-p. 13). Donors were projected to provide 96% of the resources with the Government of Malawi providing the remainder including the 2% commitment to HIV/AIDS from line ministries (Government of Malawi 2004, Annex 1-p. 18). The projected funding gap for the 2005-2009 NAF was approximately US\$198 mm or almost 32% (Government of Malawi 2004, p. 39). Similarly, the extended NAF for 2010-2012 projects a gap of US\$235.91 mm or 36% of the plan. One cost driver, particularly in the extended NAF for 2010-2012, is Malawi's commitment to provide universal access to anti-retrovirals. Despite Malawi's significant accomplishment in increasing the number of people with advanced HIV/AIDS infection receiving anti-retrovirals from just over 13,000 in 2003 to just over 196,000 in 2009, the universal access target is 280,000 for 2010 and the NAF's own target is 360,000 for 2012 (Government of Malawi Office of the President and Cabinet 2009, p. 48). Given these ambitious goals, the NAC's own budget indicates challenges with what is referred to as absorptive capacity, meaning its systems and programmes are not at a scale to spend the resources it has. The NAC underspent its

budget by 64% in 2005/06, 31% in 2006/07 and by 29% in 2007/08 (Government of Malawi Office of the President and Cabinet 2009, p. 52) suggesting that the organisation and its implementing partners did not execute against the magnitude of the plan and the scale of available resources. More resources are essential to achieve universal access, but that is not the whole story as there must be capacity to keep pace which requires both time and investment.

**Figure 11: Malawi NAC's HIV/AIDS Projections**



The NAF for 2010-2012 proposes a continued scale-up of Malawi's response to its HIV/AIDS epidemic, but the existing Global Fund Rolling Continuation Channel grant will not suffice. Even though Malawi's anti-retroviral therapy programme depends on Global Fund resources, Malawi was not successful in its application to the first Global Fund National Strategy Application round in 2009 even though it was one of the countries selected to apply for this first 'learning wave' (see Chapter 5). In 2008/09 procurement for the HIV/AIDS programme was estimated at US\$3 mm per month which included treatment for opportunistic infections, drugs for sexually transmitted infections and HIV test kits (Government of Malawi Office of the President and Cabinet 2010, p. 113). While

the Rolling Continuation Channel grant can be received for up to six years, Malawi's reliance on donor funding, as Figure 11 suggests, makes each Global Fund grant application critical to continue its HIV/AIDS programme and sustain the gains that have been made. Subsequent to its failed National Strategy Application, Malawi was also unsuccessful in its Round 10 application submitted in the summer of 2010 which proposed to continue to scale up its HIV/AIDS response, including its goals related to increasing the Prevention of Mother to Child Transmission. Failing two Global Fund grant rounds demonstrates that Malawi's scaled up response remains dependent on governing a complex landscape of institutional interests and politics, but is also vulnerable if donor support and in particular Global Fund support is not sustained at or increased beyond its current levels.

## **5. Conclusion**

If a new aid architecture is emerging as Bourguignon and Sundberg (2007, p. 319) suggest, in practice as Malawi's experience demonstrates, it may be in its early days. Malawi's ownership of its strategic development priorities and funding tied to performance are subject to the vagaries of achieving implementation and outcomes in a country faced with intractable political, economic and social circumstances, a challenging biomedical and socially rooted epidemic, and despite a weak infrastructure, a complex institutional landscape of interests and priorities in which donors participate. As Christiansen and Rogerson (2005, p. 4) advocate, before an aid architecture can be said to serve an internal coherence among donors, Malawi's institutions, and Malawians affected by HIV/AIDS, "...we need to go beyond the development system's longstanding internal narratives and constructions. We need to engage with the powerful political forces that shape the institutional and behavioural parameters in which aid is occurring." In other words, Malawi's aid dependence and its reliance on and vulnerability to its Global Fund relationship in order to respond to its devastating HIV/AIDS epidemic are a lot like the aid

architecture of old. The emergence of a new aid architecture envisioned by Bourguignon and Sundberg remains elusive.

## **Chapter 5 - Malawi: The Mediated Space for Country Ownership and the Double Deficit in External Accountability**

### **1. Introduction**

The question is, what is a country (Government of Malawi/NAC Representative 2010, interview, Lilongwe)?

‘Country ownership’ is a term that crops up often in donor literature but its meaning is usually implied rather than made explicit. The concepts and practices associated with country ownership are varied and encompass a broad interpretation of ‘who’ is meant by country, ‘what’ is meant by ownership and ‘how’ this ownership is conferred. The first section of this chapter explores how country ownership recasts the historic neo-liberal relationship between IFIs and developing countries, its association with more effective aid and its technical definition in the Paris Declaration and Accra Agenda. It describes how the Global Fund’s country level governance model creates a mediated space for country ownership. It looks at how in Malawi the elite character of country leadership and country ownership unfolds, a character that is at odds with normative ideals of broad citizen participation associated with country ownership. Finally, this section concludes by observing that the Global Fund’s internal accountability mechanisms create a rational ‘plumb line’, ultimately aligning the interests of actors in the mediated space for country ownership to the Global Fund and its donors.

The second section of this chapter describes Malawi’s failed National Strategy Application to the Global Fund and the criticism of its HIV/AIDS prevention strategy which elucidates the country ownership and external accountability challenges that arise when global politics and country evidence collide. The chapter argues that country ownership is

conceptually convenient because it implies liberal democratic values associated with participation (Strand 2007, p. 227). In practice, the Global Fund's country ownership model occurs in a mediated space where legitimate government authority and accountability for a country HIV/AIDS agenda is dispersed among elite state, non-state, national and international actors. As a consequence a double deficit in external accountability arises where no mechanisms exist for Malawians affected by HIV/AIDS to hold to account the Global Fund and its organs including the independent TRP and similarly to hold to account elite decision makers in Malawi's mediated space for country ownership particularly non-state national and international actors. The failure at the feet of this double deficit in external accountability accrues to those whose lives are or will be affected, who are without redress or recognition when prevention and treatment programmes can't be scaled and in the longer term may even be at risk. As noted in Chapter 3, while the solution to the HIV/AIDS pandemic may be collective, the problem is becoming increasingly isolated and attributed to poor and disease endemic countries like Malawi.

## **2. Country Ownership: A Break with the Past**

### Redress for the Failures of the Washington Consensus

Country ownership in its most general sense implies a departure from the mode of lending historically attributed to the IMF and the World Bank which tied loans to country governments to conditions for economic reform and structural adjustment. Without going into the robust and lengthy debate on these practices, in a nutshell structural adjustment loans have been criticised as, "a mechanism of forcing free market economics on countries through coercion" (Abbasi 1999, p. 1003); further, the increased economic activity and material output predicted by the IFIs either did not materialise, or did not necessarily lead

to better policy or a better quality of life for the majority of the people who were intended to benefit from them (Ugalde and Jackson 1995, p. 529; Burnside and Dollar 2000, p. 864; Devarajan, Dollar and Holmgren 2001, p. 6). Country ownership then, implies a different relationship between lender or donor and recipient from that historically practised by IFIs where countries were required to implement neo-liberal macroeconomic policies in order to receive loans.

Accepting country ownership as something other than a top down or coercive relationship, tells us what is *not* implied by the term, rather than what is. The OECD's Development Assistance Committee's (DAC) 1996 report *Shaping the 21st Century: The Contribution of Development Co-operation* (OECD 1996, p. 13) reflected a donor government vision for aid in the new millennium which emphasised the role of "partnerships" and a "people centred, participatory and sustainable development process" where "[p]aternalistic approaches have no place...and local actors should progressively take the lead while external partners back their efforts to assume greater responsibility for their own development." The notion of wider participation in decision-making particularly from civil society at country level was echoed, albeit faintly, in the UN's 1997 manifesto for reform *Renewing the United Nations* (1997, clause 84) which stated that "[t]he global commons are the policy domain in which this intermingling of sectors and institutions is most advanced." Notionally, OECD countries were pushing for a more deliberative space to facilitate coherent development policy making in partnership with developing countries. The UN's more restrained endorsement may have reflected the cautiousness of some states towards shifting control in the relationship between donors and recipient governments and recipient governments and non-state actors (see Chapter 6 for a discussion on legitimate public authority beyond states as it related to the Global Fund's growing authority).

By the end of the 1990s, the World Bank had become an advocate for the type of development reforms set out by the OECD. In 1998 Stiglitz (1998, pp. 27 and 1), then the World Bank's Chief Economist, promoted "putting the country in the driver's seat" after the "failures of the Washington Consensus." In laying out his vision for a "new paradigm", Stiglitz (1998, p. 21) advocated that,

[d]evelopment cannot be just a matter of negotiations between a donor and the government. Development must reach deeper. It must involve and support groups in civil society; these groups... give voice to often-excluded members of society, facilitating their participation and increasing ownership of the development process.

In 1999, under President Wolfensohn, the World Bank introduced its Comprehensive Development Framework. The Poverty Reduction Strategy Paper (PRSP) was the Comprehensive Development Framework's mechanism for implementing equitable, sustainable development and to redress the "painful realization of development agencies, recipient countries, and aid analysts...[that] the full potential of international aid to reduce poverty by achieving positive, sustainable development results was not being fulfilled" (World Bank 2003, p. xvii). Among the four principles underpinning the Comprehensive Development Framework were country ownership—in this case meaning citizen participation in "shaping development goals and strategies", and country-led partnership—in this case meaning a reduction in the "inefficiencies, asymmetrical power relationships, and tensions of donor-led aid initiatives" (World Bank 2003, p. xviii). The World Bank declared its leadership for a new type of aid relationship which was to include participation from donors, recipient governments and non-state actors alike.



Even though it marked a departure from past IFI practices, the concept of country ownership advocated by the World Bank was just that, a concept. Its practice was a more delicate matter. Booth (2008, pp. 2) describes country ownership as “the kind of political leadership, developmental vision and willingness to transform state structures that have been associated with successful development in the past.” It is a more nuanced understanding than Stiglitz’s often repeated phrase of “putting the country in the driver’s seat.” Booth acknowledges that fostering country ownership of this nature is challenging for both donors and recipient countries. For donors, the challenge lies in “abandoning the quest for guarantees” and accepting more risk while at the same time engaging with countries to develop institutional systems and policies that support development, rather than taking a hands-off approach. For countries, Booth (2008, pp. 3-4) suggests that the challenge lies in leading development efforts which he maintains are unattractive to politicians because “getting re-elected is a complicated business in which slicing up the national cake is usually more important than enlarging it”, or put another way, neo-patrimonialism (discussed further in Chapter 6) is “profoundly anti-developmental” (Booth 2008, p. 2).

As discussed in Chapter 3, when legitimate authority is dislocated from the realist-positivist focus on the nation state, agenda setting is “open to the input and disruption of a variety of political agents” (Stone 2008, p. 26). Country ownership promotes the notion of citizen participation as a ‘good thing’, the exercise of liberal democratic values. But as discussed later in this Chapter, the normative ideal may depart from the reality on the ground where decision making remains in the hands of the elite. Poku and Sandkjaer (2007, p. 12) note the “...widening gap between Africans at large and African elites [where] [i]n many countries elite control of the state systems ensures their access to both the dwindling economic opportunities and the mechanism for state power (military and

police forces) ensuring that economic and political privilege are protected.” Buiter (2004, no page) in his scathing analysis of country ownership observes that “[c]ountries subject to IFI programs and the associated conditionality often have political systems that are unrepresentative and repressive...The political leadership and the elites supporting it are often corrupt and economically illiterate...[and] [p]ublic administration is weak, corrupt and has very limited implementation capacity.” At first blush, the notion of country ownership paints a virtuous picture of the extent of participation of non-elites in decision making. It fails to acknowledge those that Stiglitz called the ‘often-excluded’ may remain so.

What is evident from the successive campaigns which advocate for country ownership is that they reflect a past left behind, a rejection of the ethos of the structural adjustment era. As Khan and Sharma (2001, p. 14) observe, “[t]here is unlikely to be “full” ownership, and the problem is really one of trying to maximize ownership within the context of conditionality.” In other words, country ownership lies in a mediated space, where the ‘who’ of country may include non-state actors but this may be far from the ‘often-excluded’, and ‘what’ is meant by ownership and ‘how’ this ownership is conferred is somewhere between ‘full’ ownership and little ownership at all. More cynically Buiter (2004, no page) contends that this mediated space is so large as to make the term country ownership meaningless, where it is anything from “... ‘the country has designed and drafted the programme’...[to] ‘the authorities of the country are kept informed of how and when the program has been implemented’.” In practice the boundaries of country ownership, and in particular those that demarcate the legitimate authority of a country’s government to design and achieve equitable, sustainable development are not clearly drawn.

## Technocracy and an Emerging Aid Architecture

The 2005 *Paris Declaration on Aid Effectiveness* is a compact between donors and recipient countries outlining a series of commitments to improve aid effectiveness which ultimately are intended to result in all countries achieving the MDGs. What distinguishes the OECD's Paris Declaration from the World Bank's efforts to recast the delivery of aid and achieve sustainable development is that the Paris Declaration marked the first time that both donors and recipients endorsed one framework: the 'we' of the Paris Declaration is "Ministers of developed and developing countries responsible for promoting development and Heads of multilateral and bilateral development institutions" (OECD 2008, p. 1). This inclusion signified the emergence of a new aid architecture (see Chapter 4 which discusses the extent to which an aid architecture can be said to be emerging in Malawi), involving both donors and recipient governments where a country's ownership of its development strategy was a core feature (Bourguignon and Sundberg 2007, p. 319).

With its focus on aid effectiveness, the Paris Declaration takes a technical approach to development, defining commitments and actions, measurable indicators and a monitoring and evaluation approach. Country ownership is front and centre as the first of five themes, with "partner countries" (read recipient governments) committing to exercise "effective leadership over their development policies, and strategies and co-ordinate development actions" (OECD 2008, p. 3). Similar to the OECD's 1996 donor driven vision for aid delivery and the World Bank's 1999 Comprehensive Development Framework, the Paris Declaration proposes that country ownership require recipient governments to:

[e]xercise leadership in developing and implementing their national development strategies through broad consultative processes[; t]ranslate these national development strategies into prioritised results-oriented operational programmes as

expressed in medium-term expenditure frameworks and annual budgets...[; t]ake the lead in co-ordinating aid at all levels in conjunction with other development resources in dialogue with donors and encouraging the participation of civil society and the private sector (OECD 2008, p. 3).

Donors' commitment involved exercising "respect [for] partner country leadership and help[ing to] strengthen their capacity to exercise it" (OECD 2008, p. 3). The indicator associated with country ownership was the proportion of recipient governments which have "operational development strategies" (OECD 2008, p. 9), and although donors committed to respecting country leadership, it is of course highly subjective as to how or whether or not this occurred. While the subject of the Paris Declaration is national development strategies, its focus is very much on process and measurement which Booth (2008, pp. 2) warns "will not crack the problem of the non-developmental priorities of the politicians who lead poor countries." In other words, achieving equitable, sustainable development is a complex and nuanced undertaking, and seeking compliance to a set of proclamations is not enough to achieve it.

Three years after the Paris Declaration, the *Accra Agenda for Action* told a similar country ownership story under the headline "[w]e need to achieve much more if all countries are to meet the Millennium Development Goals..." (OECD 2008, p. 15). Like its predecessor, the *Accra Agenda* identified country ownership as "key" in order for "[d]eveloping countries [to] determine and implement their development policies to achieve their own economic, social and environmental goals." It identified three strategies to strengthen country ownership: 1) "broadening the country level policy dialogue on development" where parliaments are responsible for country ownership and all actors including "central and local governments, CSOs, research institutes, media and the private sector are engaged

in policy dialogue”; 2) strengthening capacity of institutions, systems, and local expertise, where developing countries are responsible and donors support these efforts; and 3) “strengthen[ing] and increas[ing] the use of country systems” where developing countries are responsible for improving these systems and donors assist this process through using them (OECD 2008, pp. 16-17). In the language of the Accra Agenda, the ‘who’ of country ownership is developing country governments and ‘what’ is owned are development policies and systems for governance and implementation. Actors beyond government participate in policy deliberation and the role of donors, although more robust than that outlined in the Paris Declaration, for all intents and purposes changed little from the OECD position twelve years earlier, where donors “back their [recipient country] efforts to assume greater responsibility for their own development” (OECD 1996, p. 13).

Donors, recipient countries and non-state actors made up the 1700 participants at the Third High Level Forum on Development Effectiveness which endorsed the Accra Agenda. Not surprisingly then the Accra Agenda includes a specific commitment to deepen engagement with civil society (OECD 2008, p. 18), although the ‘we’ taking action remain donors and recipient governments. As Stiglitz (1998, p. 21) cautioned when he advocated for a new development paradigm which “reaches deeper” than the donor and recipient government relationship, although non-state actors are critical to achieving desired country “ownership and transformation”, they are not necessarily representative. Booth (2008, p. 2) takes this caution a step further noting that the inclusion of non-state actors in determining country development priorities does not necessarily lead to equitable and sustainable development as non-state actors “face incentives [which are]...not always more conducive to progressive policy actions than those motivating presidents and ministers”; further, he suggests that from a donor perspective, the extent to which donors contribute to positive development outcomes depends on *how* they approach country ownership. In other words

they are “complicit in the prevailing political arrangements:” just because actors are not the ‘state’ does not necessarily mean that citizen participation is enhanced or achieved or non-elite, ‘often-excluded’ actors have a role. The Accra Agenda sidesteps questions of the representativeness of non-state actors by limiting those committing to action to donors and recipient country governments. As a result, country ownership, and it follows accountability for development, rests almost entirely with recipient country governments. ‘How’ donors engage with or are complicit in the “prevailing political arrangements” is the clue in an otherwise neat, technical vision that the country ownership space may be a mediated one.

The Paris Declaration and the Accra Agenda speak to the emergence of a new aid architecture where country ownership is key, donors and recipient country governments endorse their respective commitments to improve the quality of aid, and civil society participates in the development discourse. The technical approach of these compacts delineates the intentions of both donors and recipients and infers that if there is compliance aid quality will be realised and all countries will meet the MDGs. But as Booth suggests and as discussed later in this chapter, in practice the incentives and interests of donors, recipient governments and non-state actors make for a much more complex and messy reality. The mediated space for country ownership escapes explicit definition and remains subject to “the powerful political forces that shape the institutional and behavioural parameters in which aid is occurring” (Christiansen and Rogerson 2005, p. 4).

The Global Fund has promoted the principle of ‘national ownership’ from its inception. Its Framework Document claims, “[t]he Fund will base its work on programs that reflect national ownership and respect country-led formulation and implementation processes” (The Global Fund, no date-c, ‘The Framework Document’, p. 1). The language is

reflective of the dominant aid effectiveness narrative, but the term ‘national ownership’ (or country ownership) lacked definition. It is not clear from the Global Fund’s perspective, at least in its Framework Document, ‘who’ is meant by national and ‘what’ it is that is owned.<sup>26</sup>

The Global Fund is signatory to the Paris Declaration and the Accra Agenda (The Global Fund 2010d, p. 1) and as such it promotes the notion of national or country ownership but with a distinct Global Fund flavour. On the one hand the independence of its country level governance mechanisms “put the country in the driver’s seat.” On the other hand, the participation and influence of national and international non-state actors in governance and decision making goes beyond notions of ‘engagement’ and ‘consultation’ recognising ‘country’ to be more than its government. Advocating for country ownership may be conceptually convenient because it implies alignment to democratic liberal values (Strand 2007, p. 227). In practice, however, it is a more complicated matter.

Three features of the Global Fund’s country level governance model help to shape its practice of country ownership:

- The Global Fund has no country office and therefore the CCM and the TRP through the Global Fund application process help to set the agenda for and define country programmes related to the three diseases and health systems strengthening. A locally contracted Local Fund Agent provides independent monitoring of the Principal Recipients’ implementation and stewardship of funds;
- The Global Fund’s inclusive governance approach is manifest in the delegations which it encourages comprise the independent CCM such as government ministries and national and global NGOs, faith based organisations and CSOs (see Chapter 3 for a discussion on legitimacy associated with inclusiveness and transparency); and

- The TRP, comprised of individual experts, is also independent from the Global Fund secretariat and board and makes recommendations to the board on grant awards.

The CCM then becomes a locus for setting the agenda and funding a country's HIV/AIDS response especially, as discussed in Chapter 4, in a country like Malawi there the Global Fund is not only the major funder of this response but a significant donor overall. The TRP enables this agenda because it recommends whether or not CCM proposals are funded or declined and therefore although it is independent from the Global Fund secretariat, its individual experts are particularly influential over what happens at country level. Like the TRP, the CCM is not part of the Global Fund secretariat and neither is it a government organisation. The Global Fund structures its country level governance so that 'national ownership' (or 'country ownership') occurs in a mediated space beyond government where state and non-state and national and international actors convene. In Malawi the CCM took an elite form. Civil society is typically weak in Malawi and even though Malawi's CCM included Malawian CSOs, several CCM members acknowledged that this was not the same as having a voice or exerting influence over agenda setting (International CCM Members, 2010, interviews, Lilongwe). The fact that the country ownership space is mediated is one thing but that does not necessarily mean it is constituted or functions in a way that is more inclusive or deliberative as the ideals associated with country ownership suggest. The nature of this mediated space for country ownership has implications for both the leadership and ownership of a country's HIV/AIDS response.

#### Country Leadership and Setting the HIV/AIDS Agenda



Country leadership as laid out in the Accra Agenda is a critical component of ownership: “[d]eveloping country governments will take stronger leadership of their own development policies, and will engage with their parliaments and citizens in shaping those policies” (OECD 2008, p. 15). Leadership of an HIV/AIDS agenda, because of the economic, social and biomedical nature of the disease, necessarily rests in multiple ministries and parastatal organisations and the inter-institutional dynamics can be contentious, as Malawi’s example shows.

Malawi exerts strong central policy leadership for its HIV/AIDS response claiming ownership for both its development and the oversight of its implementation: As described in Chapter 4, the Department of Nutrition, HIV and AIDS in the Office of the President and Cabinet (OPC) has overall policy ownership. The NAC develops and oversees the implementation of the National Action Framework for HIV/AIDS and the Ministry of Health and Population (MoHP) oversees the broader Programme of Work for health including the Extended Health Package and the Health Sector Wide Approach (SWAp) and provides biomedical expertise and leadership for the HIV/AIDS response:

Up until now, the government says do this and everybody does it, and that’s that. The government is clear that it is in charge and everyone has to do what the government or President says. It is very hierarchical. ‘The boss has said therefore we do without question’ approach seems to be very typical of this country. It’s more than just the old man [the then President of Malawi, Bingu wa Mutharika]. It seems that culturally they are very hierarchical (International CCM Member 2010, interview, Lilongwe).

Walt and Gilson (1994, p. 355) reinforce this observation with their claim that setting policy is a function of context and the actors involved:

Context is affected by many factors such as instability or uncertainty created by changes in political regime or war; by neo-liberal or socialist ideology; by historical experience and culture. The process of policy-making (how issues get on to the policy agenda, how they fare once there) in turn is affected by actors, their position in power structures, their own values and expectations. And the content of policy will reflect some or all of the above dimensions.

Malawi's central leadership of HIV/AIDS policy may in part be a function of culture and history. What is evident is that the three pivotal state and parastatal organisations in Malawi's HIV/AIDS response make a strong ownership claim for setting its priorities.

Despite the formal roles attributed to the Department of Nutrition, HIV and AIDS in the OPC, the NAC and the MoHP, the balance of power among these organisations and the underlying dynamics between their leaders has at times been contested. Historically, there has been an "institutional tug of war" between the NAC and the Department of Nutrition, HIV and AIDS in the OPC, which has been in part due to the institutional independence of the NAC and in part due to the leaders involved:

NAC used to have a very strong leader, Bizwick Mwale...[and there is also] the OPC, with Dr. Mary Shawa, who is the head of the Department of Nutrition, HIV and AIDS who more clearly wants to position the OPC as the overseer and direction giver to everyone else. NAC has given lip service to following that but has been doing their best not to, as much as I can tell, at least until recently...OPC should be doing the strategic work, the policy work, leaving the programmatic oversight to NAC, though NAC has been much more of an implementer than they should have been (International CCM Member 2010, interview, Lilongwe).

Malawi's Law Commission has drafted HIV/AIDS legislation which proposes to further consolidate leadership for the country's HIV/AIDS agenda. The legislation proposes to create a "legal institutional framework for the regulation and coordination of matters pertaining to HIV/AIDS" (Malawi Law Commission 2007, p. 2), with a provision to move the NAC directly into the OPC thereby removing its independence. Some anticipate that this erosion of the NAC's parastatal status will be regressive (NGO Representative 2010, interview, Lilongwe) but any ambiguity about leadership of the HIV/AIDS agenda would be resolved.

Another change for the NAC is that its status as the only Principal Recipient for Global Fund HIV/AIDS resources is coming to an end. At the recommendation of the TRP, the CCM has recently approved three new Principal Recipients: "It will erode their [NAC's] power. They will have to give in some" (NGO Representative 2010, interview, Lilongwe). While Malawi has exhibited strong central leadership, the balance of power between the OPC and the NAC has been on shifting sands. The proposed transition of the NAC from an independent organisation to part of the OPC and the inclusion of additional Principal Recipients are likely to contribute to further consolidating authority in the OPC for agenda setting, weakening the NAC's leadership and implementation oversight role.

While biomedical leadership for the HIV/AIDS response is attributed to the MoHP, in practice observers have noted poor coordination between the OPC and the MoHP and to a lesser extent the NAC, and a diminishing of MoHP leadership capacity:

Mary Shawa's office [OPC] has been talking about a cadre of HIV/nutrition workers that should also take up HIV/AIDS testing and counselling and ARV [anti-retroviral] refills in the community... When you talk to the MoHP about these plans, they don't know, or they have never heard about it... Sometimes you observe

there is not enough communication going on between departments... To have a Principal Secretary for Nutrition, HIV and AIDS when you have a MoHP with an HIV/AIDS department is a bit strange (Government of Malawi/NAC Representative 2010, interview, Lilongwe).

Others have postulated that the MoHP's weak leadership has affected its ability to negotiate an appropriate role with partners:

In general, the relationship between the MoHP and the NAC has been good... But... there are areas where it has not gone well. And I think it's to do with... at the MoHP a lack of leadership overall... there is a lack of leadership and there is a lack of vision and a lack of direction and a lack of accountability... a lot of the well experienced senior managers in the ministry were made to leave over the years... [and as a result] there was very little expertise in public health and health care delivery. This has weakened the position of the Ministry vis à vis the NAC... [and the MoHP is] not always a strong negotiation partner (Government of Malawi/NAC Representative 2010, interview, Lilongwe).

Cassels (1994, p. 336) describes the dynamic of weak leadership in developing country ministries of health more generally:

The capacity to make strategic or operational decisions in many ministries of health and health care institutions is often constrained by the fact that no one is in overall charge. In the absence of clear management structures, consensus has to be reached between technical staff and generalist administrators, different professional cadres, and competing programme managers. Organizational structures frequently reflect the success of these different groups in lobbying for status rather than the

need for managerial control. Similarly, the process of resource allocation is dominated by provider rather than managerial or societal interests.

As Cassels observes, the challenges of resource constrained and socially and economically vulnerable environments like Malawi extend to the country's leadership capacity and capability. In Malawi's case, underneath the formally articulated division of leadership, there are ebbs and flows in the dynamics among the OPC, the NAC and the MoHP, with the current trend moving towards greater consolidation of leadership in the OPC. Poor communication in particular between the OPC and the MoHP and weak leadership capacity at the MoHP reinforce the ability of the OPC to direct the HIV/AIDS agenda. On the surface, 'government' leadership for and ownership of agenda-setting seems clear but underneath this mantle, the inter-organisational dynamics reveal that even for the state 'country ownership' is a political and contested landscape of who leads and who influences what.

### Country Ownership and Setting the HIV/AIDS Agenda

The Global Fund's country level governance model expands who has a say in setting the agenda for nation's response to its HIV/AIDS epidemic and who has a stake in its implementation; however, this model does more than broaden the discursive space—it also dilutes the fiduciary financial function of government and the accountability at work in democratic processes. In the case of the former, the Global Fund awards its grants to Principal Recipients which in Malawi's case for HIV/AIDS has been the NAC, not the Ministry of Finance or even the Ministry of Health. The NAC in turn awards funds to state and non-state organisations alike (see Chapter 6 which discusses the role of CCMs in democratising or eroding the power of the "parochialisation of the political realm" (Poku

and Sandkjaer 2007, p. 13)). For non-state actors this expanded role conflicts with their traditional source of legitimacy derived from independent advocacy:

[i]ndirect affiliation through funding binds, however subtly, any NGO to the political profile and ...agenda of the donor...Any loss of independence on the part of a NGO inevitably questions the legitimacy of their claim, emphasising the critical need to be seen to be in an empathetic tie with the beneficiaries (Webb 2004, p. 31).

From an accountability perspective, the CCM disperses the legitimate authority of government by distributing it among or sharing it with national and international non-state actors, none of whom have accountability to Malawi's citizens (see Chapter 6 which discusses the 'publicness' of the Global Fund's authority). In this mediated space, country ownership--by whom and of what--contends with diverse interests, new and distributed authorities, multiple constituencies and accountability which accrues to the Global Fund.

This explicit and intentional broadening of who has a say in developing Global Fund proposals in a country and therefore implicitly in shaping a country's HIV/AIDS agenda has been positioned by some as a positive evolution in development practice: "The Global Fund would insist that they deal with the country, not the government. Most of the institutional space where health policy is negotiated is dominated by government and they have shifted that space in a helpful way I believe" (UN Executive 2009, interview, Geneva). In the case of newly democratic states like Malawi where government capacity may be weak, "...the parallelism between statism and nationalism has a limited role" (Poku and Sandkjaer 2007, p. 13) and a mediated space for country ownership may counter these effects.

The Global Fund sees wider participation as having a “catalytic effect”, responding to deficits by “building the capacity of local health leadership to improve governance of HIV programs” (Atun and Kazatchkine 2009, p. S68). Wider participation, as discussed in Chapter 6, in theory at least serves to water down systems of patronage among the political elite, thereby reducing the potential for resources to be channelled away from the vulnerable in favour of the powerful and wealthy or worse, displacing them through corruption (Poku and Sandkjaer 2007, p. 12). This watering down was not evident in Malawi where an elite enclave of government representatives and international donors and NGOs led the CCM and the agenda setting. The discursive space that the CCM model was intended to catalyse may be broader than the state but in practice not broad enough to mean that citizen participation reaches the ‘often-excluded’.

#### The Mediated Space for Country Ownership: Anarchy or a Rational Force?

The mediated nature of country ownership was evident in Malawi:

There are many partners involved, all with slightly different roles and different agendas which relate to country leadership. The question is what is a country? What is a national discussion? It is heavily influenced by the different partners. It comes from inside the country and outside the country. If you talk to the country leadership, it is basically ‘what is the national discussion?’ which is not always completely agreed to by the Malawian Government. A good example is the whole discussion about male circumcision which was not initiated or supported in the country, but through long term pressure and support and being put on the agenda by international partners, it has become part of the national agenda (Government of Malawi/NAC Representative 2010, interview, Lilongwe).

While the government in Malawi claims to retain strong ownership of policy and the HIV/AIDS response, the reality is that the CCM is a locus of influence because of its role in creating applications to the Global Fund and then overseeing the grants that are received: “I sit on the CCM and it acts as a pretty good coordination body on HIV/AIDS...And although its purpose is quite clear, it also acts as a forum for HIV/AIDS issues beyond the Global Fund grants” (International CCM Member 2010, interview, Lilongwe). The dynamics in Malawi of agenda setting for HIV/AIDS and the role of the CCM in this process demonstrate that the Global Fund’s country level governance stretches the country ownership notion far beyond the donor / recipient government construct of the Accra Agenda.

If the Global Fund’s country level governance model ascribes the ‘who’ in country ownership to a range of state and non-state and national and international actors, and ‘what’ is owned is agenda-setting such as that for a country’s HIV/AIDS response, then ‘how’ this agenda is shaped is also an important consideration. Fidler (2007, p. 8) characterises the interests and influence of a range of stakeholders as resembling a form of “open-source anarchy”, and anarchy by definition resists the order of “rationalization, centralization, and harmonization.” The complexity of this interaction is echoed by Walt et al. (2009, p. 63) who describe the vagaries of the global / national interplay:

In terms of the literature on global architecture, the focus has been largely on global actors and their attendance at meetings to discuss or to agree to new policies or initiatives. There has been much less attention played [sic] to their agency: the interaction of these different actors, how far their actions may be governed by their interests, and how these reflect and are reflected in their ideas, values, motivations and exercise of power and the ways in which these may be affected by any particular governance arrangement.



The influences of actors and the agency they exercise on national agenda setting might, as Fidler (2007, p. 11) describes, “move beyond highly structured paucity and unstructured plurality towards purposeful plurality.” Rather than this rational force which acts on a mediated space for country ownership coming from international frameworks like the Accra Agenda, it is embedded in the authority and hierarchical internal accountability exercised by the Global Fund (Chapter 3 describes the Global Fund’s internal accountability model). As discussed in Chapter 6 in relationship to the Global Fund’s growing authority, this rational force counters patterns of “disorder, randomness, and an absence of rational imposition of planning” identified by Stone (2008, p. 22). What Fidler (2007, p. 9) describes as “source code” is inherent in the old-fashioned donor/recipient power asymmetry, between the Global Fund’s authority, its performance-based funding and its internal accountability and an aid reliant, HIV/AIDS endemic country like Malawi. This accountability plumb line stabilises the interplay among diverse interests, new and distributed authorities and multiple constituencies in the mediated space for country ownership. The problem that arises however is one of external accountability. As the next section will describe, there are no mechanisms for Malawians affected by HIV/AIDs to hold accountable participants in the mediated space for country ownership--particularly elite, non-state national and international actors--or to hold accountable the Global Fund and its organs including the TRP. Rather, accountability goes one way, from Principal Recipients up through the Global Fund and on to its donors.

At first glance, country ownership might appear to describe the provenance of a state over its policy-making and agenda setting and signal a departure from what were perceived as coercive and unsuccessful neo-liberal development practices of the IFIs. The Global Fund ascribes to ‘national ownership’ or ‘country ownership’ and is a signatory to the Paris Declaration and the Accra Agenda which broadly promote country ownership as a

government's autonomy over its development agenda, the engagement of non-state actors, and donors in a supporting role. In practice CCMs with their inclusive membership broaden the notion of country beyond the state to create a mediated space for country ownership where the object of action in the instance of Malawi's CCM is the country's HIV/AIDS agenda. However, as the experience in Malawi demonstrates, non-state is not the same as 'often-excluded' and the CCM remains an elite forum. Beyond the practical advantages that greater inclusivity provides where health service delivery is concerned, it is normatively convenient, embedding democratic, liberal values in what is described as an emerging aid architecture (Bourguignon and Sundberg 2007, p. 319; Strand 2007, p. 227; Bonnel 2009, p. 165); but this belies the anarchy inherent in the multiplicity of actors and interests that influence country agenda setting in a mediated space (Christiansen and Rogerson, 2005, p. 1; Birdsall 2007, p. 593; Booth 2008, pp. 2; Walt, Spicer and Buse 2009, p. 63). The rational force on these dynamics lies in the old fashioned donor/recipient power asymmetry between the Global Fund and an aid reliant, HIV/AIDS endemic country like Malawi, where incentives to fulfil and comply with the Global Fund's performance-based funding and internal accountability are high. The problem that arises however is one of external accountability: there are no mechanisms for Malawians affected by HIV/AIDS to hold accountable participants in the mediated space for country ownership or the Global Fund itself. And as with any governance model, its true test—its legitimacy, authority and accountability—comes when times are tough, when grant applications to the Global Fund fail. The next section of this chapter will discuss Malawi's HIV/AIDS prevention strategy associated with its failed 2009 National Strategy Application to the Global Fund.

### **3. The Mediated Space for Country Ownership: The Collision of Global Politics and Country Evidence in Malawi**

The following section explores the effects of a mediated space for country ownership using the example of Malawi's *National HIV Prevention Strategy* for 2009 to 2013 which was attached to its failed National Strategy Application to the Global Fund. It looks at the context in which Malawi developed its proposal to the Global Fund and how the TRP's feedback on the failed application created a collision between a 'global social-political order' and Malawi's ownership of its HIV/AIDS agenda. The section concludes with a discussion on how global political interests can exacerbate the mediated nature of country ownership especially for an aid reliant, HIV/AIDS endemic country like Malawi revealing a double deficit in external accountability.

#### Malawi's HIV/AIDS Prevention Strategy and a Global Human Rights Agenda

Policy-making--and by association agenda setting--is by nature messy (Stone 2008, p. 29). The TRP's challenge to Malawi's *National HIV Prevention Strategy* for 2009 to 2013 which formed part of the country's failed National Strategy Application to the Global Fund exemplifies the unpredictability and fragmentation that Stone (2008, p. 29) associates with global policy processes but fit just as well in a country context.

In 2009, Malawi was one of seven countries invited to submit an application to the Global Fund's 'learning wave' for its first round of applications for its National Strategy Approach (The Global Fund 2010n, p. 4). (Chapter 6 discusses the Global Fund's National Strategy Approach in relation to its growing country-level authority). The country visit by a Strategy Review Team designed to help Malawi develop its application and Malawi's successful history of Global Fund applications set expectations among CCM members that the application would be successful.

Everyone who was invited to apply for the National Strategy Approach should have been given the opportunity to succeed. What would also have been useful was

a continued refinement of the proposal so that the success is increased. Those were the signals we got from both the TRP and the secretariat earlier on. So the desk review was successful, the TRP came to the country and was very positive about the programme and the extended National Action Framework and so we felt that we were going to be successful. And then when the proposal was submitted, it wasn't [successful] and then an effort to engage further to see how to refine it really wasn't something where the door was open (International CCM Member 2010, interview, Lilongwe).

The application's failure came as a shock and the TRP cited three main reasons for its decision: Malawi's failure to take meaningful action to rectify the shortcomings of the Central Medical Stores (see Chapter 6 which refers to the drug stock outs in Malawi) which has had longstanding procurement and supply chain challenges; the need for more Principal Recipients in addition to the NAC, and weaknesses in the HIV/AIDS prevention strategy. One critique of the HIV/AIDS prevention strategy was its lack of focus on men having sex with men.<sup>27</sup> Those who had participated in developing the country's prevention strategy disagreed with the TRP's assessment and defended its credible and evidence-based<sup>28</sup> approach:

I know the difference between how you focus on the general population and how you focus in concentrated epidemics. I was appalled by the TRP's comments. I've worked with the men having sex with men community in so many different countries. I feel like there is a very, very small vocal voice advocating. Go ahead and advocate, but it's not evidence-based to focus a prevention strategy on a very small minority percentage of the population that are very hard to identify and actually have the same transmission rates as urban men. Yes, you're much more vulnerable because you're not going to access healthcare, but it's not the crux of

the epidemic here. And the fact that it was men having sex with men and not sex workers. The sex workers here are a big problem. They are being ignored and they have 70% HIV prevalence. I thought that we had a very, very strong, evidence-based, national prevention strategy and we had experts from all over the world working on it. We have a very evidence-based National Action Framework which is what the National Strategy Application was based on and a very strong appeal. If that was one of the main reasons, I can't even say how that goes against everything in terms of evidence-based programme implementation. It's activism (International CCM Member 2010, interview, Lilongwe).

CCM members including donors supported an appeal to the TRP which also failed. The TRP's feedback was perceived by some as imposing a global human rights agenda on Malawi's HIV/AIDS response (UN Representative 2010, interview, Lilongwe) and exemplifies a tension inherent in 'country ownership' when a country's agenda departs from global level interests. As a Global Fund Executive observed,

[t]his example [the TRP's feedback to Malawi on the lack of focus on men having sex with men in its HIV/AIDS prevention strategy for its failed National Strategy Application] points to real tensions between country ownership and global principles and principles of human rights. What do we do if women are minors but gender and equality drive the epidemic? It's very delicate and difficult, not black and white. It's the responsibility of AIDS advocates and normative agencies to work with countries to point to vulnerable groups...In the Malawi case it was devastating for the country because the partners had worked together hard on the proposal (Global Fund Executive 2010, interview, Geneva).

Shortly after the TRP's initial decision was submitted to the November 2009 Global Fund board meeting for approval, Malawi became the focus of global media attention because two men who had participated in a traditional engagement ceremony were imprisoned and charged with gross indecency under the penal code. Homosexuality carries a maximum sentence of 14 years in Malawi (Nyasa Times, December 30 2009, 'Not Guilty Gay Couple Pleads in Court'). The men were pardoned in May 2010 after a visit to Malawi by Ban Ki-moon, the Secretary General of the UN (Nyasa Times, May 29 2010, 'Malawi President Pardons Jailed Gay Couple'). A diplomatic intervention from the highest level of the UN in a country's domestic legal and social affairs makes evident the political weight of the global human rights agenda and in particular the strong interest in advocating for the rights of homosexuals.

To lend some reflective context to these events, p. 276 provides a high level comparison of the HIV/AIDS prevention strategies of the three sub-Saharan African countries which applied to the Global Fund's National Strategy Approach learning wave. Of the three, only Rwanda succeeded in its application. As TRP deliberations are private, it's not possible to draw conclusions about their rationale and decision making. However, from comparing these strategies submitted by Malawi, Rwanda and Kenya, some broad observations can be made. For example, all three countries have epidemics in the general population driven by discordant couples meaning that one or both people engage in sex with other partners. HIV/AIDS prevalence varies with Malawi having the highest at 12% and Rwanda the lowest at 3%. None of the countries has much, or in some cases any, data on vulnerable groups such as sex workers and men having sex with men. Both Rwanda and Kenya estimate that 15% of new infections occur in the men having sex with men population, while Malawi did not specifically attribute new infections to this group. Rwanda is the only country among the three which outlines its intention to develop programmes with the

men having sex with men population and to conduct more research. Both Malawi and Kenya are vague on their specific intentions, citing a cross-cutting approach without a specific course of action. From a human rights perspective, Rwanda is the only country where homosexuality is legal. While none of the countries has addressed the human rights of vulnerable populations, Rwanda was the only one which included the intentional statement that “[u]nderpinning all of these strategies is a commitment to ensuring greater participation of members of these [marginalised] groups in assessing their needs, designing programs, and advocating for necessary changes in the environment” (Government of Rwanda 2009, p. 45). However, human rights is only one factor--albeit an important one--on which to assess the economic, social, biomedical, and health system strengths of an HIV/AIDS prevention strategy.

Finally, given the earlier assertion that the TRP’s feedback was a form of activism, it is worth considering the progress on human rights for homosexual populations in the developed world. The United States, the Global Fund’s largest donor, decriminalised sodomy as recently as 2003 with the ruling in *Lawrence et al. v. Texas* which stated that “...two adults...with full and mutual consent, engaged in sexual practices common to a homosexual lifestyle...[and these p]etitioners' right to liberty under the Due Process Clause gives them the full right to engage in private conduct without government intervention” (FindLaw 2003, ‘*Lawrence et al. v. Texas*’). There was not a global level diplomatic intervention in the political and legal systems of the United States to prevent legal persecution of a segment of its population prior to 2003.

The coincidence of Malawi’s failed National Strategy Application and the diplomatic intervention by the UN Secretary General heightened sensitivity towards the TRP’s feedback. At the time research was undertaken in Malawi for this thesis, debate was

underway among CCM members about how to change the HIV/AIDS prevention strategy for the Round 10 application to the Global Fund. Given that Malawi's HIV/AIDS response is highly dependent on Global Fund resources there was real and genuine concern about the prospect of a failed Round 10 application:<sup>29</sup>

For this Round 10, there is a lobby to focus more on treatment, because there is a concern in the Malawi Government that they will get another rejection. So they said let's leave out some of the very sensitive areas with these vulnerable groups like men having sex with men and prison populations. It's all in the prevention strategy but maybe they will not include it as much in Round 10. Because there are concerns about issues that are not yet resolved for Malawian society and there is a concern that if you make it too ambitious that you will get rejected again. There is a lot at stake for this proposal. People are nervous about it (NGO Representative 2010, interview, Lilongwe).

The feedback from the TRP on Malawi's prevention strategy for its failed National Strategy Application illustrates the influence of Global Fund processes and the independent TRP experts on country agenda-setting. It is a clear example where country ownership—country here includes state and non-state and national and global partners—is diminished when global politics and in particular a global human rights agenda comes into play.

### The Politics of Influence

Although the CCM is a forum where development partners—which include multilateral and bilateral donors and international NGOs—participate in setting the agenda for Malawi's HIV/AIDS response, historically it has not had an influential role (International CCM Members 2010, interviews, Lilongwe). The CCM is one of several health and HIV/AIDS



fora in which development partners participate (see Chapter 4 for a description of Malawi's health sector). Others include the Health Donors Group and technical working groups associated with the Health SWAp, the HIV/AIDS Development Group, the coordinating mechanisms of the NAC, including the Malawi Partnership Forum and the technical working groups and sub-groups that advise the NAC. At the time of field research for this thesis, Malawi's CCM was chaired by the Secretary to the Treasury and included representatives from the OPC, the NAC, multilateral and bilateral donors, international NGOs, local NGOs, faith based organisations, and people living with HIV/AIDS, tuberculosis or malaria. In other words, from the point of view of representation, the CCM's composition ticked all of the Global Fund's boxes.

In the case of Malawi's CCM, despite its inclusiveness, in the past there was little engagement particularly from national non-state actors. In part this was due to Malawi's weak civil society as a newly democratic country with a decade's long legacy of authoritarian rule. One of the CCM members spoke of the challenge of engaging civil society:

It has become quite difficult [to get Malawian civil society voices included in the CCM's deliberations] because the government determines a lot of the things that people do and people seem to be patient with government. When things take time, they accept the excuses provided and then the next time, the next time, the next time, and then it [has been] ten years (International CCM Member 2010, interview, Lilongwe).

Malawi's CCM became a forum for elite decision makers: the NAC and government ministries, donors and international NGOs.

In terms of...the CCM, the theory is wonderful, but I don't know of any country where in practice it's a real entity....[Is] the CCM a well-functioning entity that has an idea of its roles and responsibilities? Not really...the CCM gets together when it's called together and people rubber stamp what they need to rubber stamp. Is it perceived by its members as a governance institution? Not really. A new CCM has been constituted just recently. It's possible that it could become a governance entity, an overseer of what the Global Fund in this country does, it could become more of a serious player (International CCM Member 2010, interview, Lilongwe).

Because of Malawi's historic success with Global Fund applications, there was little incentive to change its CCM model. Malawi was also demonstrating significant progress in scaling up treatment. The failed National Strategy Application challenged this comfortable status quo.

Malawi's failed National Strategy Application had a galvanising effect for CCM members providing what has been described by some as a "wake up call" (International CCM Member, NGO Representative 2010, interviews, Lilongwe):

If you look at the National Strategy Application...the government played a significant role and we as partners supported that effort and went to bat for them. In Round 10 however, it has been a combined dialogue...There's a greater role for the other constituents now in defining the goals and strategies for this Round 10. NAC is part and parcel of the discussion, but members other than [the] NAC within the CCM were able to define what that package would look like. This time around it was the partners (International CCM Member 2010, interview, Lilongwe).

Development partners were on the verge of making the CCM a more active force and inclusive forum in agenda setting for Malawi's HIV/AIDS response, a move away from a

highly centralised, government and NAC owned model to one where more and diverse interests would have real influence and the broader country ownership dynamic could take root.

Without strong engagement from a broader ‘country forum’ through the CCM, it’s not surprising that the TRP’s feedback on Malawi’s HIV/AIDS prevention strategy related to its failed National Strategy Application was influential. In this case there was the power asymmetry inherent in the traditional donor/recipient grant relationship and the long term nature of Malawi’s need:

Because this is a competitive process necessarily [the National Strategy Application process], over time what the Global Fund will realise and has started to realise is that they have lives at stake when they don’t fund some of these really large programmes and Malawi is one of the largest. And the Global Fund has been at the forefront of pushing the value for money movement...And we still need to figure out what that really means. There is value for money, but there is still a lot of need out there. It’s becoming more and more difficult when the TRP makes a decision, lives are at stake. And so now for us it’s do or die for Round 10, literally. If we don’t get this, we can’t roll out the WHO 2009 guidelines, and a whole bunch of other things are in jeopardy (International CCM Member 2010, interview, Lilongwe).

The Global Fund’s weight as a donor and Malawi’s reliance on its funding to provide treatment to almost two thirds of Malawians with advanced HIV/AIDS undoubtedly influences Malawi’s HIV/AIDS agenda; however, the TRP’s feedback on Malawi’s HIV/AIDS prevention strategy entered a political domain where national and international values collided. Castells (2008, p. 80) characterises this influence as the result of the

emergence of an “international public sphere” through which citizens, civil society, and the state communicate which creates a “global social-political order” where states “cling to the illusion of sovereignty despite the realities wrought by globalization.” In the case of the TRP’s feedback and influence on Malawi’s HIV/AIDS prevention strategy, it was clearly perceived by CCM members as a situation where values embraced in the global sphere were imposed on the Malawian context. As one interviewee posited (UN Representative 2010, interview, Lilongwe):

A proposal can be well documented, well written with facts on the ground but if it is not addressing what donors want, it can easily wipe out. So the issues of human rights, if they come on their own, it can be a hard way [for them] to penetrate, so the best way is [for them] to come in through the back door which is [along with] HIV/AIDS.

In the case of Malawi’s failed National Strategy Application, the agility with which the values of the ‘global social-political order’ found their way onto a country agenda, despite support from CCM members for the country’s HIV/AIDS prevention strategy, may have been exacerbated by weaknesses in participation and dialogue within the CCM itself. Okuonzi and MacRae (1995, p. 131) describe the dynamic whereby these weaknesses unduly favour the global actor:

The weakness of national fora for discussion, reinforced by the lack of information available on the likely outcomes of different policy options, has brought into sharp contrast the power of international agencies to control the policy domain. This situation has heightened the need for policy partnerships between international and national actors, rather than the politics of domination which currently predominates.

The Global Fund claims, and rightly so, that its investment has positive benefits and a “catalytic effect” on country stewardship of HIV programmes (Atun and Kazatchkine 2009, p. S68); however, the TRP’s influence on Malawi’s HIV/AIDS prevention strategy reveals a more complex dynamic. Country ownership and evidence-based decision making may be the desired methods of governing the HIV/AIDS response at country level, but influence comes from sources beyond even the broadly conceptualised and mediated space for country ownership; moreover, this influence is not limited to a granting relationship and an HIV/AIDS response. It has a political dimension which exists in an international public sphere where defacto global governance emerges (Castells 2008, p. 89). In this case a global human rights agenda came into conflict with epidemiological evidence and the social and legal constructs in Malawi. Without a CCM acting as a strong ‘national public sphere’ Malawi’s ownership of its HIV/AIDS agenda in the face of the interests of a ‘global social-political order’ is at best mediated and at worst fails.

#### The Double Deficit in External Accountability

The mediated space for country ownership is problematic when it comes to external accountability, or “accountability to people outside the acting entity, whose lives are affected by it” (Keohane 2002, pp. 14-15). (Chapter 3 discussed the Global Fund’s output oriented legitimacy and its accountability link). When the ‘country’ in country ownership includes state and non-state and national and international actors, accountability and its mechanisms—for what and in whose interests— are difficult to define. The traditional notion of accountability is reflected in Held and Koenig-Archibugi’s (2004, p.127) straightforward definition:

Accountability refers to the fact that decision-makers do not enjoy unlimited autonomy but have to justify their actions vis-à-vis affected parties, that is,

stakeholders. These stakeholders must be able to evaluate the actions of the decision-makers and to sanction them if their performance is poor, for instance by removing them from their positions of authority. Thus, effective accountability requires mechanisms for steady and reliable information and communication between decision-makers and stakeholders as well as mechanisms for imposing penalties.

Similar to Held and Koenig-Archibugi, Bartsch (2007b, pp. 11-13) describes the dimensions of accountability relative to GHIs (or what she calls Global Public Private Partnerships) as giving an account (providing information on its activities), taking account (providing mechanisms to increase its responsiveness to and participation of stakeholders) and being held to account (providing mechanisms which allow for control and sanctions). Conceptually, the mechanisms necessary for accountability can be identified, but how accountability functions (or doesn't function) is much more chaotic and difficult to divine when country ownership in a mediated space waters down the rationality of locating legitimate authority with the nation state.

If accountability as it relates to country ownership only concerned itself with the Global Fund being accountable to donors and Principal Recipients being accountable to the Global Fund, then Held and Koenig-Archibugi's and Bartsch's models might suffice. This hierarchical accountability is what Keohane (2002, p. 14) characterises as "internal accountability", a stabilising plumb line. As discussed earlier, the accountability challenge for the Global Fund and for the participants in Malawi's mediated space for country ownership lies in the lack of external accountability. In other words from an external accountability perspective, who among those who participate in Malawi's mediated space for country ownership for HIV/AIDS--a space created by the Global Fund--including state

and non-state, and national and international actors are accountable to Malawians affected by HIV/AIDS and how are they held to account?

A review of Malawi's *National HIV Prevention Strategy* for 2009 to 2013 offers no clues--accountability is inferred rather than made explicit. The NAC claims "accountability" for its leadership and coordination (National AIDS Commission 2009, p. 41) but there is no indication of how this is conferred or sanctioned. The strategy reflects the devolution of health service delivery to the local level by indicating that District AIDS Coordinating Committees, Community AIDS Coordinating Committees and Village AIDS Coordinating Committees are accountable for planning and implementing local interventions (National AIDS Commission 2009, p. 61) but provides no indication of on whose behalf or how they are held to account. The document describes a consultative process for creating the strategy involving a range of stakeholders, expert advice from a National Task Force, and approval from a National Steering Committee, but there is no explicit indication of what this participation infers and whether there is any accountability in the sense of Bartsch's description of 'taking account'. For the most part, roles and responsibilities may be identified, but accountability is not ascribed. For example, the strategy provides targets for reducing the incidence and prevalence of HIV/AIDS in the population; however, who is accountable for achieving the targets, on whose behalf, and the sanction that could be employed or the disincentive that could occur if the targets are not met is not addressed. Accountability might be seen to be partially addressed through Global Fund monitoring and evaluation requirements, but this is internal accountability to the Global Fund rather than laying out an accountability model in a country ownership context. In Malawi's HIV/AIDS prevention strategy document, answers to questions of who is accountable to whom, for what, and with what consequences are not in evidence.

From the interviews conducted in Malawi, responses to questions of accountability were, not surprisingly, varied. Some maintained that the government is ultimately accountable for implementing a successful HIV/AIDS response (International CCM Member 2010, interview, Lilongwe). Conversely, another observed that “the government is all for being in charge, but don’t ask them to be accountable” (International CCM Member 2010, interview, Lilongwe). One development partner described its own accountability for effectively responding to the epidemic as shared with government but then retreated from this view to say that partners were only facilitating (International CCM Member 2010, interview, Lilongwe). This lack of alignment and clarity was echoed by an interviewee at global level:

The whole definition of accountability needs to be turned on its head in terms of donors. We always write this into programme agreements—all partners will be accountable—but what does this mean? What are the indicators? There is a missing link that we are not able to have a legally enforceable accountability system that holds accountable the Global Fund, the WHO and [iNGOs] for that matter. The population has no way to ensure their rights. The same for national governments—it’s different to expect something other than aspirations – what are the obligations? It’s not easy to hold governments to account. Most African nations haven’t met the Abuja targets for health (NGO Representative 2010, Interview, Geneva).

The challenge of external accountability is broader than Malawi’s HIV/AIDS prevention strategy. As Stone (2008, p. 23) observes in relation to transnational policy communities,

[o]ne outcome of this disjuncture [that economic globalisation and regional integration are proceeding at a much faster pace than processes of global



government] is that the power of the nation-state has been reduced or reconfigured without a corresponding development of international institutional cooperation.

This is one of the major causes of a deficiency of public goods at global levels.

It can be argued that this disjuncture could also cause a deficiency of public goods at country level, where accountability for developing, implementing and funding an effective, evidence-based HIV/AIDS prevention strategy is not defined and therefore neither are the sanctions to enforce it.

Scholars describing governance and accountability within and across webs of actors beyond the traditional confines of the state have largely focused on describing some feature or form of global governance (Benner, Reinicke and Witte 2004, p. 194; Slaughter 2004a, p.160; Grant and Keohane 2005, p. 29; Stone 2008, p. 20). In contrast, Grant and Keohane (2005, p. 34) question the existence of a juridical or sociological global public and instead rely on a “clearly defined public” in democratic nations in order to provide “the responses to the fundamental questions about accountability.” In both instances, the focus is on the global sphere and the presumption of a clearly defined public. The existence of a ‘national public sphere’ particularly a mediated space for country ownership is neglected.

If indeed the TRP’s feedback to Malawi on its evidence-based HIV/AIDS prevention strategy was a form of activism as one interviewee suggested then Malawians affected by HIV/AIDS or those who could be affected in the future have no mechanism to hold decision makers-- the CCM, the independent TRP members and the Global Fund board--to account. The only sanction Malawians affected by HIV/AIDS have is through democratic process, but the mediated space for country ownership means that the ‘national public

sphere' is not entirely public or entirely democratic. Scholte (2004, p. 212) points out the inadequacy of democratic accountability when national and global interests are in play:

...relationships between national governments and global governance agencies have mainly flowed through unelected technocrats who lack any direct connection with citizens. Moreover, governments have on the whole intervened with global governance institutions only in respect of broad policy lines, leaving the supranational bodies with considerable unchecked prerogative in operational activities. In short, then, the conventional statist formula of democratic accountability does not suffice in relation to present-day expanded global governance.

The mediated space for country ownership that plays out through the Global Fund's CCM has practical advantages in theory, broadening the involvement and stake of many partners in order to tackle a country's HIV/AIDS response. But it comes with a serious double deficit in external accountability. First it ignores the power asymmetry in the donor/recipient relationship between the Global Fund, the largess of its contribution to aid reliant and HIV/AIDS endemic Malawi, and Malawi's long term arc of need. It also ignores the separation between Malawians affected by HIV/AIDS and those involved in agenda setting and decision making at country level in the absence of the boundaries provided by the legitimate authority of the nation state. The Global Fund's global and country level governance models serve the Global Fund's internal accountability model well. But where external accountability is concerned not only does the Global Fund created mediated space for country ownership exacerbate the external accountability gap, but the TRP's influence, apparent activism and absence of accountability to 'country owners' only serves to intensify it. At the feet of this failure in external accountability are the Malawians who are at risk because they are reliant or will become reliant on ARV

treatment procured with Global Fund resources. The politics of prevention has a long-term effect:

...increasing mortality among the most economically active members of African societies translates into low adult productivity a generation or two later. The net effect of an AIDS-depleted society is a challenge to development resulting from the potential-hollowed states and social networks. For these reasons, HIV/AIDS may well pose the gravest threat to socio-political and –economic development in Africa (Poku 2005, p. 11).

#### **4. Conclusion**

The term ‘country ownership’ is conceptually convenient providing a soothing antidote to the legacy of structural adjustment and signalling the emergence of a new aid architecture as laid out in the Paris Declaration and the Accra Agenda. However, in practice the Global Fund’s CCM model creates a mediated space for country ownership where ‘country’ includes actors beyond the state, both national and international. The rational force at play does not come from technical efforts at effecting a new aid architecture; rather it is inherent in the old-fashioned donor/recipient power asymmetry between the Global Fund’s authority, its performance-based funding and its internal accountability and an aid reliant, HIV/AIDS endemic country like Malawi. This accountability plumb line stabilises the interplay among diverse interests, new and distributed authorities and multiple constituencies in the mediated space for country ownership. It also gives rise to a double deficit in external accountability.

Malawi’s 2009-2013 HIV/AIDS prevention strategy places the country’s challenge in stark human terms: “While the national ART [anti-retroviral] programme has been successful in scaling-up antiretroviral therapy (ART) to about 200,000 Malawians by end December

2008, the number of new infections estimated at 90,000 per year continues to outpace the number of people starting ART each year” (National AIDS Commission 2009, p. 8). As the case of Malawi’s failed National Strategy Application and the feedback from the TRP on its accompanying HIV/AIDS prevention strategy points out, country ownership may be advocated by the Global Fund, but this principle can be overlooked when a human rights agenda and the interests of a ‘global social-political order’ enter the deliberation; furthermore, the principle of country ownership does nothing to reflect the chaotic and in Malawi’s case elite nature of the mediated space in which this ownership exists or the problematic double deficit in external accountability that arises.

Global governance scholars largely leave out the ‘country’ space in favour of a transnational or transgovernmental level analysis; this glosses over the limitations of the Global Fund’s own internal accountability which accrues to its donors and the problems of external accountability in a mediated space for country ownership. The implications of the TRP’s feedback on Malawi’s evidence-based HIV/AIDS prevention strategy are that the challenge of a double deficit in external accountability is more than a philosophical issue. For Malawians affected by HIV/AIDS or those reliant on the implementation of an evidence-based HIV/AIDS prevention strategy, there are no mediated spaces between life and death.

## **Chapter 6 - The Global Fund and Country Ownership - The Weak Authority-Accountability Link**

### **1. Introduction**

For a year now we've been doing crisis management. A key issue which we continually educate patients on is adherence, adherence, adherence [to their anti-retroviral drug regimen]. We've proven that adherence in rural communities can be as good as the developed world. But now with this situation [stock outs of anti-retrovirals] ...we are contradicting ourselves. And the patients know because we've told them continuously that they risk developing resistance [to the effectiveness of the drugs]. They know the dangers. It makes them unhappy and doubtful about how things will continue--that maybe one day the medicine will not be there (Health Care Worker 2010, interview, Zomba).

Chapter 1 began with recounting the failure of the international community to mobilise a response to HIV/AIDS when it was first recognised and the scale of the pandemic that resulted: 60 million people have been infected with HIV and nearly 30 million people have died of HIV/AIDS related causes. In 2011, 4% of the approximately 22 million people living with HIV/AIDS in Sub-Saharan Africa had access to treatment (UNAIDS 2010d, p. 23). Despite this bleak account, in Malawi as outlined in Chapter 4, progress has been made with almost 26% of the estimated 920,000 Malawians living with HIV/AIDS accessing treatment (UNAIDS 2010f, 'Malawi'). But headline results are not the whole story and they belie the messy reality of implementation and implementation failures on the front lines.

As described in Chapter 5 Malawi's failed 2009 National Strategy Application which would have supported a continued scale up of the country's HIV/AIDS response came about in part because the Global Fund's TRP challenged Malawi's evidence-based HIV/AIDS Prevention Strategy. The failure of Malawi's CCM's National Strategy Application revealed a double deficit in external accountability, where Malawians affected by HIV/AIDS could not hold to account the CCM actors in the Global Fund created mediated space for country ownership, nor could they or the CCM hold to account the TRP whose decision making was described as a form of activism. The stock outs of anti-retrovirals in Malawi in 2009 and 2010 were a different type of failure, a failure of a drug financing and supply system. The 2009 stock outs were a result of delays in signing the Global Fund Rolling Continuation Channel grant which in turn delayed drug orders. When stocks of drugs were low again in 2010, "no funding from the Sector Wide Approach (SWAp) was allocated to bridge the gap, nor did any of the individual health donors step in to assist" (Médecins Sans Frontières 2010, p. 27). As a result, some patients had to change their anti-retroviral drug combinations, putting them at risk for developing resistance to the drugs. In addition patients were given two weeks of pills instead of two months, increasing transportation costs and consequently the likelihood treatment would be interrupted or stopped as well as increasing the workload for already burdened health workers (Médecins Sans Frontières 2010, p. 27). When global and country level systems fail the people who they intend to serve, how are those in authority held to account and by whom?

The discussion that follows begins by looking at the basis for legitimate authority beyond the state, the legitimising nature of the Global Fund's 'publicness' and the contrast with its internal accountability to and influence of wealthy and powerful states. It makes a case for the Global Fund's growing authority as an innovative and quickly maturing international

institution. At global level, its growing authority is evidenced by its leadership in health systems strengthening. At country level its growing authority is evidenced by its adoption of a National Strategy Approach. Finally, the chapter turns to the problem of the dislocation between the loci for authority and accountability which is both exacerbated and obscured by the ‘publicness’ of the Global Fund’s authority and its rapid rise. In the words of one interviewee (International CCM Member 2010, interview, Lilongwe), “[t]he big question is whether the Global Fund is set up for this type of burden of responsibility. And I would argue that it is probably not.”

## **2. Authority and the Demise of the Public/Private Dichotomy**

The forces of globalisation have created forms of legitimate authority beyond the state (Ruggie 2004, p. 504; Pattberg 2005, p. 591), where “[a]s long as there is consent and social recognition, an actor –even a private actor – can be accorded the rights, the legitimacy, and the responsibilities of an authority” (Biersteker and Hall 2002, p. 204). This discussion will not delve into the robust and complex literature on sovereignty and authority or exhaust the many forms of authority which scholars posit such as that derived through moral claims or expertise (Hall and Biersteker 2002, p. 4). Rather, it will explore the nature of legitimate authority beyond states and in particular the legitimating ‘publicness’ of the Global Fund’s authority contrasting it with the influence of and its internal accountability to wealthy and powerful states.

Chapter 3 outlined broad themes in the literature on legitimacy making the case for the Global Fund’s innovative institutional design as new sources of legitimacy distinct from those of traditional multilaterals. It discussed the dislocation that arises when legitimacy cannot rely on the realist-positivist idea of authority of the nation state and state-governed global institutions or as Stone (2008, p. 26) describes when “[a]genda setting is more

contested, externalized beyond the nation-state, and open to the input and disruption of a variety of political agents.” In the context of globalisation and an emerging post-Westphalian order, Ruggie (2004, p. 519) argues that authority lies in a *new* global public domain, “...an institutionalized arena of discourse, contestation, and action organized around the production of global public goods...[which] is constituted by interactions among non-state actors as well as states.” This new global public domain fundamentally challenges “...the liberal conception of the public/private distinction [which] turns fundamentally on the separation between the administrative state and civil society—one dichotomy being mapped to the other” (Weintraub 1997, p. 14). Geuss (2001, p. 6) takes things a step further suggesting “letting go” of the dissolved liberal distinction and instead accepting a “series of overlapping contrasts.” Similarly Bozeman and Bretschneider (1994, p. 199) advocate for what they call a “dimensional” analysis, examining the implications of Geuss’ dissolution on external political authority rather than clinging to attempts to assign it a ‘publicness’ or ‘privateness’. The neat lines once demarcating public from private authority are blurred and the challenge lies in determining how new boundaries are being drawn and who it is who is drawing them (Krieger 1977, p. 256).

As Bozeman and Bretschneider suggest, the demise of the liberal distinction, or what Weintraub (1997, p. 14-15) colourfully terms “procrustean dualism”, leaves open to description the nature of the authorities that are emerging in what has been a predominantly liberal conceived public domain. According to Hall and Biersteker (2002, p. 5), “[t]he state is no longer the sole, or in some instances even the principal, source of authority, in either the domestic arena or in the international system.” Cutler (1999, p. 73) argues the case for political authority that comes with the porousness of economic exchange:



The challenge [in locating and identifying authority globally] lies in depicting authority in a late-capitalist and post-modern world where "political" authority ostensibly stops at the territorial borders of the state, while "economic" relations do not. Liberalism masks the "political" nature of these economic exchanges and obscures the extent to which the territorial state has ceased to run coextensively with the "right to rule" or is definitive of and constitutive of political authority.

In Bull's (2010, p. 227) view, concern over whether authority gained through representation in international organisations--including the Global Fund--is public or private is eclipsed by another--the extent of concentration of representation among individual members of the global elite or the coalescing of an elite authority. These propositions highlight the many dimensions of emerging authorities and the declining dominance of authority associated predominantly with the state. Stone (2008, p. 22) describes these new public spaces as the "global agora,"

...[which] makes no presumptions about the communicative, progressive, or deliberative character of institutional or network interactions. The dynamics for exclusion, seclusion, and division are just as likely. A "global agora" encompasses a wider array of political relationships inspired by liberal democracy through to coercive arrangements of strong authoritarianism, as well as to patterns of disorder, randomness, and an absence of rational imposition of planning.

In other words, the liberal conception of the public/private distinction has not only dissolved but the result is a chaotic array of political relationships vying for authority which are likely to lie outside the comfortable boundaries of sovereignty. This authoritative disorder presents advantage for those who can lay claim to territory in a contested space.

### The ‘Publicness’ of the Global Fund’s Authority

As discussed in Chapter 3, the Global Fund has derived its legitimacy from sources distinct from those of traditional multilateral institutions like the WHO, namely through its inclusive governance at global and country levels, its transparency and performance-based funding and the scale of its resource mobilisation and distribution. These sources of legitimacy are subject to claims of ‘publicness’. According to Hurd (1999, p. 381), “[t]o the extent that a state accepts some international rule or body as legitimate, that rule or body becomes an “authority””; further, the Global Fund’s claims that inclusive governance and transparency in particular facilitate participation in decision making by non-state actors amplifies the normative claim to ‘publicness’ of its authority where there exists “a fusion of power with legitimate social purpose” (Ruggie 1982, p. 382).

Conferring a ‘publicness’ on the Global Fund’s authority not only diverges from its governance model which departs from the ‘doctrine of sovereignty’ but also contrasts with its strong internal accountability model which accrues to wealthy and powerful states. By its own definition the Global Fund is a public/private partnership (The Global Fund 2010a, ‘About the Global Fund’), yet, as Chapter 3 establishes, although its distinct sources of legitimacy may have normative and legitimating public qualities seen as being “by the people” (Scharpf 1999, p. 2), they remain output-oriented. This output orientation supports the Global Fund’s strong internal accountability model which accrues to the donor governments who provide its financing, and as noted in Chapter 2, to its largest funder, the United States. Not only does this suggest an elite authority, it may as Bull (2010, p. 227) claims, “tilt agendas toward the priorities of the elite.” This suggests a model where authority ‘over’ is ultimately exercised by wealthy and powerful states, but the authority ‘given’—for what and by whom—is much less clear. This is in part due to the

mediated space for county ownership created by the Global Fund which, as demonstrated by the case of Malawi's failed National Strategy Application, constitutes the first part of a double deficit in external accountability. The second part is constituted by a failure in external accountability by the Global Fund's TRP. An interviewee familiar with the drug stock out situation in Malawi described failures attributed to the 'authorities' involved:

With the delay in signing the RCC [the Global Fund Rolling Continuation Channel grant which is the primary grant for HIV/AIDS in Malawi], all the funding stopped. There was no overstock in the supply chain—only 1.5 months in the whole country. The challenge with UNICEF [at the time UNICEF was running Malawi's HIV/AIDS drug procurement and supply chain] is that they will not move anything until the money hits their account, so any administrative delay has a huge impact...NAC didn't want to say there was a problem. They tried to get money from other donors to buy buffer stock...Donors then say that if the government hasn't said there is a problem, then there is no problem. The government is afraid that there might be negative consequences for the rest of the negotiations [for the release of Global Fund money]. The Global Fund also denies that there is a problem (NGO Representative 2010, interview, Geneva).

The 'publicness' conferred on the Global Fund's authority is at odds with the power asymmetry inherent and the coercion implied in a traditional donor/recipient relationship (Hurd 1999, p. 386). While authority 'over' and the power of wealthy and powerful states is clear, the 'giving' of authority—how and by whom---is much less so as is the accountability that might go with it, particularly when failures occur.

The next section will explore the rapid rise in the Global Fund's authority. It will look at how the Global Fund derives its legitimate authority from its bureaucracy particularly in

the eyes of donor governments and global partners and through the changes in social relations that have occurred through its country level governance model. The section will argue that the Global Fund's expansion into health systems strengthening and its National Strategy Approach are evidence of its expanding scope of authority and power. This expanded authority further exacerbates the Global Fund's weak authority-external accountability link.

### **3. The Global Fund's Authority: A Rapid Rise**

#### Authority and Bureaucracy

Weber (1947, pp. 330-1) characterised bureaucracy as a relationship between obedience and authority, where rational legal authority is “a continuous organization of official functions bound by rules...” within a “specified sphere of competence...” that “follow[s] the principle of hierarchy...” Barnett and Finnemore (2004, p.3) soften the edges of Weber's rational conception to define bureaucracy—in which they include international institutions as a form of bureaucracy--as a “distinctive social form of authority with its own internal logic and behavioral proclivities.” Despite associating bureaucracy with social forms of authority, Barnett and Finnemore do not abandon rationality. They describe the exercise of bureaucratic authority as derived in part from its “ability to make impersonal rules” and maintain that “because of their authority...bureaucracies have autonomy and the ability to change the world around them” (Barnett and Finnemore 2004, p.3). Similar to Weber, Barnett and Finnemore argue that bureaucratic authority, including that of international institutions, relies on more than the exercise of ‘impersonal rules’. Bureaucratic authority is conferred through legitimacy:

Bureaucracy is powerful and commands deference, not in its own right, but because of the values it claims to embody and the people it claims to serve. IOs

[international organisations] cannot simply say, “we are bureaucracies; do what we say.” To be authoritative, ergo powerful, they must be seen to serve some valued and legitimate social purpose, and, further, they must be seen to serve that purpose in an impartial and technocratic way using their impersonal rules....Bureaucracies always serve some social purpose or set of cultural values, even when they are shrouded in myths of impartiality or value-neutral technocracy (Barnett and Finnemore 2004, p.21).

Bureaucracy applied to international institutions can be seen as a form of authority which is conferred a ‘publicness’ or “a fusion of power with legitimate social purpose” (Ruggie 1982, p. 382). However, regardless of the normative force of legitimate social purpose, the term ‘bureaucracy’ does not always infer social or humanitarian benefit. It can also be used to imply negative characteristics associated with inefficiency and unresponsiveness—the downside of the exercise of impersonal rules.

The Global Fund’s distinct sources of legitimacy--in particular its inclusive governance at global level and its performance-based funding--underpin its bureaucratic authority. The Global Fund’s inclusive governance model was an attempt to address what was perceived as a breakdown in the ability of bureaucratic international institutions to adapt and respond to the complex nature of their ‘publics’ beyond states due to their inefficiency, weak transparency and poor deliberative engagement with national and transnational civil society (Benner, Reinicke and Witte 2004, p. 194; Nanz and Steffek 2004, p. 319; Castells 2008, p. 88; Sridhar, Khagram and Pang 2009, pp. 7-8; Cooper, Kirton and Stevenson 2009, p. 5). At global level, the Global Fund’s board provided a new model and set of rules by including non-state actors in governance and emphasising transparency implying that broader participation in decision making is possible. In addition to these normative

claims, the Global Fund's performance-based funding, a highly rational tracking of investments and results was seen by donor governments to be an improvement on the accountability practised by UN organisations and an incentive to invest in the Global Fund (Wallace Brown 2009, p. 170). Its sources of legitimacy tell a normative story about the Global Fund's inclusiveness, transparency and accountability and provide "binding norms" and "rational rules" (Weber 1947, pp. 954) that were envisioned as departures from the poorly functioning bureaucracy of the UN. As discussed previously, claims associated with inclusiveness and transparency in particular confer a 'publicness' on the Global Fund's authority.

The Global Fund has had a remarkably quick ascent in terms of its size and the resources it commands. At inception, the rationale for the creation of the Global Fund outside the UN system was that it would escape the negative connotations associated with UN bureaucracy and the participation of private actors in its governance would bring a market discipline (implying efficiency) with its hybrid organisational form (Buse and Walt 2000a, p. 552; Buse 2004, p. 225). Despite the intention to avoid the vices of bureaucracy and claim the virtues of efficiency, the Global Fund has matured organisationally so that by early 2011, it had a staff complement of 568 (The Global Fund 2011e, 'Secretariat'), and had mobilised just over US\$30 bn (The Global Fund 2011c, 'Pledges and Contributions') for distribution to 150 countries (The Global Fund 2011b, 'Grant Portfolio'). The Global Fund was intended to be the antithesis of a bureaucratic UN organisation, but its legitimacy and its normative 'publicness' has contributed to its organisational maturation towards a bureaucratic form, a "rationally regulated" authority" (Weber 1922, p. 954), laying claim to territory once the exclusive domain of multilaterals governed by the 'doctrine of sovereignty'.

## The Global Fund's Growing Global Level Authority: Health Systems Strengthening and the Health Eight

The Global Fund's organisational maturation, bureaucratisation and the accompanying growth in its authority among global health leaders is evident in the role it has taken globally in health systems strengthening. Health systems strengthening is an expansion of the Global Fund's initial mandate to provide vertical funding for three diseases and an area in which the WHO and the World Bank have traditionally laid normative and financial claim respectively. Despite the attention given to the health systems strengthening agenda at global level, in Malawi the focus remains access to treatment, a disconnect from the territorial manoeuvring at global level.

As described in Chapter 2, the WHO's leadership at global level has waxed and waned over more than 60 years. It has largely been seen as a technical and convening organisation, with the expertise to research and set standards and guidelines (Lee 2009, p. 103). Its role as the 'leading health organisation' however is predicated on supporting its technical capacity with its ability to promote cooperation among state and non-state actors (Zacher and Keefe 2008, p. 97; Kickbusch 2009, p. 328; Lee 2009, p. 10) to drive normative agendas such as the Alma-Ata Declaration of "health as a fundamental human right" (World Health Organization 1978, p. 1).

As discussed in Chapter 2, in the early 1990s the WHO's global health leadership role was eclipsed by the World Bank. The Bank overrode the WHO's 'health for all' social justice values with its 1993 *World Development Report* which advocated a neoliberal economic approach to health and argued for greater efficiencies and a more prominent role for the private sector (Brown, Cueto and Fee 2006, p. 68, Zacher and Keefe 2008, p. 97, Kickbusch 2009, p. 327; Lee 2009, pp. 111-2). Moreover, by 1995 the World Bank was

“the largest single source of external funding for health” (World Bank 1993, p. 166). But despite their respective normative and financial strengths, by the late 1990s the health leadership roles of the WHO and of the World Bank were challenged by the emergence of other actors with an interest in the health agenda:

Alongside WHO has emerged a multiplicity of players...The World Bank maintains a prominent place because of its unrivalled financial resources and policy influence. Regional organizations, such as the European Union, and other UN organizations (e.g. UNICEF, UNDP, and UNFPA) retain health as an important component of their work...The Organization for Economic Cooperation and Development (OECD) and World Trade Organization (WTO) approach health from an economic and trade perspective. Varied civil society groups, such as consumer groups, social movements and research institutions, also make substantial contributions to health development. Finally, the growth of private sector actors in health, within and across countries, is notable (Dodgson, Lee and Drager, 2002, p. 11).

By the beginning of the new millennium, the global health landscape had transformed from one with leadership by a few to one with a range of actors, the Global Fund prominent among them. Global level leadership in health was no longer the exclusive domain of the WHO and the World Bank.

Within this newly populated landscape, health systems strengthening emerged as a focus and point of discussion for G8 leaders at the 2008 Toyako Summit (Miyata 2008, p. 1). Health systems strengthening came to the fore because of some of the unintended consequences of disease-focused programmes which included, for recipient countries, an array of uncoordinated programmes with significant funds and multiple donors, increased



costs of servicing these programmes and increased demand on the capacity of already strained health ministries, and skewed incentives for health professionals to work in better-funded disease programmes, rather than in primary care (Takemi and Reich 2009, p. 10-11). For G8 governments, it was becoming evident that improvements in health systems were necessary in order for their commitments to and investments in disease focused programmes like that of the Global Fund to have their intended effects and for the health MDGs to be achieved. As a consequence, there was nervousness among vertically oriented programmes like the Global Fund about shifts in global resources to health systems (Takemi and Reich 2009, p. 10).

As described in Chapter 2, in 2009, the Global Fund and the GAVI Alliance made a bold claim to global leadership in health systems strengthening. The Global Fund and the GAVI Alliance wrote to the IHP+ Co-Chairs, then-United Kingdom Prime Minister Gordon Brown and then-President of the World Bank Robert Zoellick to advise of their intention to underpin their leadership in health system investment with a joint programming approach for health systems strengthening (Lob-Levyt and Kazatchkine, 2009). Subsequent to staking their claim, the Global Fund and GAVI worked with the World Bank to “...establish in an inclusive manner the operational, financial and policy implications for joint HSS [health systems strengthening] funding and programming” (The Global Fund 2010i, ‘Report of the 13<sup>th</sup> Meeting of the Policy and Strategy Committee’). Two relatively new players in global health made an authoritative leadership claim to what had previously been the domain of the WHO and the World Bank; moreover, it was territory that lay outside the original purview of both organisations.

It would be misleading to think that the Global Fund and GAVI’s move was without contest or was a *fait accompli*. Their assertion of authority in health systems strengthening

remains contentious. “If you hadn’t had that letter [the Lob-Levyt and Kazatchkine letter], and kept on with the original initiative [we would be on our way to] producing a half way decent approach [to] getting everyone aligned. As it is we’ve been diverted into some structural mess which has no obvious signs of resolution” (UN Executive 2009, interview, Geneva).

In addition to asserting its authority among traditional international institutions and claiming ownership of health systems strengthening, the Global Fund’s growth in authority associated with its bureaucratic size and weight is evident through its inclusion as one of the Health Eight (H8), the other members of whom are the WHO, the World Bank, UNICEF, UNFPA, UNAIDS, GAVI and the Bill and Melinda Gates Foundation. The Health Eight is described as a “meeting of global health leaders [that] resembles the meeting of global political leaders...providing communication, collaboration, and consensus building on global health policy, including interactions with the G8” (Takemi and Reich 2009, p. 14-15). The composition of the Health Eight demonstrates the extent to which global health leadership has moved beyond traditional international institutions. It includes a private foundation and two GHIs, none of which are governed by states. The Health Eight’s relationship to the G8 signals its political gravitas as well as what Reich and Takemi (2009, p. 15) describe as a “power shift...[and] restructuring [of] the architecture of global health policymaking.”

The Global Fund’s role in this restructured architecture of global health policymaking along with its political influence is critical for its resource mobilisation; however, its quickly won authority and expanding mandate are amplified at country level. As the stock out of anti-retroviral drugs in Malawi shows, the Global Fund’s processes and decision making have very real effects on the ground, not all of which are positive:

In terms of the IHP+ and HSS [health systems strengthening] platform, in my view it's completely irrelevant. I don't think the Global Fund is set up to work on HSS, to work in a SWAp [sector-wide approach] environment...It's a rather dangerous irrelevance because it has taken our dialogue away from ...grant management and issues on the ground...The biggest responsibility of the Global Fund is ART [anti-retroviral] delivery...In Malawi well over 210,000 people's lives are dependent on Global Fund grants...It's not the type of situation where you can start bickering or delaying over condition precedents not being met...The big question is whether the Global Fund is set up for this type of burden of responsibility. And I would argue that it is probably not (International CCM Member 2010, interview, Lilongwe).

There is clearly a tension between the initial mandate of the Global Fund as a financing mechanism for three diseases, its design which supports this mandate and its evolved authority, which can be said to be taking the Global Fund away from its original mission. As discussed in Chapter 4, Kazatchkine, the Global Fund's Executive Director from 2007 to 2012, noted the tension between the 'treatment mortgage' for donor governments and the dependence of millions who receive ARV treatment from Global Fund resources. To be seen to manage funds effectively through performance based funding does not equip the Global Fund to respond to very real humanitarian and ethical questions where millions of lives, or 'communities of fate', depend on its granting and grant administration decisions.

The Global Fund's legitimacy, particularly its inclusive governance and its transparency and performance-based funding, have contributed to its rapid maturation and its authority associated with its bureaucratic size and weight. This in turn signals its claim to global level territory in health systems strengthening and its policy and political influence among health leaders including the WHO and the World Bank; moreover, this authority is

mutually reinforcing in the sense that the creation of the Health Eight is itself recognition that the landscape has changed and new members with non-traditional sources of authority are now a part of the global health leadership ‘club’. Nevertheless, at country level, the story can play out differently where an expanded mandate risks diluting focus on the Global Fund’s core role which in Malawi is to provide funding for the purchase of anti-retrovirals. The global level politics of claiming territory in health systems strengthening is a long way from expanding treatment to Malawians in need. The Global Fund’s growth in global level authority and its country level burden of responsibility are out of step.

### Authority and Social Relations

In contrast to the impersonal nature of bureaucratic authority, Weber (1922, p. 1006) identified patriarchy as a social form of authority derived largely through personal loyalty. The rational elements of social forms of authority lie in social ‘rules’ or customs and their normative elements in the beliefs that bind people to these traditions. Weber (1922, p. 1020) argued that normative nature of this authority is “rooted in the belief that the ruler’s powers are legitimate insofar as they are traditional.”

While authority associated with the Global Fund’s bureaucratic size and weight may be the domain of international institutions, Hyden (2008, p. 12) argues that socially-based authority and informal institutions in particular play a significant role in the African context:

Together [formal and informal institutions]...shape the articulation of power. That is why in Africa, power is not always legitimized by authority, i.e. legitimized power stemming from constitutions, laws or procedures. It comes as often from conventions, customs and other beliefs with roots in African society.

In other words, social forms of authority matter; further, despite the negative connotations with ‘poor governance’ associated with what is described as neo-patrimonialism, in African states this form of authority can be accompanied by strong economic performance (Kelsall 2011, p. 84). So there is a tension between the embedded and beneficial nature of social forms of authority and its negative aspects which can mean that formal rules are flouted and leaders “personalize their power and avoid accountability” (Khan 2005, p. 714). Where states are fragile, the negative attributes of social forms of authority can emerge.

In the case of Malawi, the fragile nature of its state authority arises due to several factors. First, as discussed in Chapter 4, Malawi is a new democracy where the exercise of political power remains volatile, giving rise to the potential for “[t]he parochialisation of the political realm...[where] due to an absence of effective structures of autonomy and strength to check corruption, the governing elite of most African states have engaged in high and sometimes egregious levels of corruption” (Poku and Sandkjaer 2007, p. 12). Second, as described in Chapters 4 and 5, among the state and parastatal organisations involved in setting the HIV/AIDS agenda and overseeing the significant funds that the Global Fund has awarded, ‘internal’ politics and as discussed in Chapter 5 the sway of elites to hold power over the national agenda are alive and well. Lastly, the very nature of Malawi’s HIV/AIDS epidemic is a threat. Poku and Sandkjaer (2007, p. 23) describe this effect as,

...a downward spiral wherein the epidemic relentlessly reduces state capacity, even as the state requires ever-increasing capacity to stop the growing epidemic. The structures of government remain, but the ability to govern is diminished...It [a ‘hollow state’] implies a weak state relying largely on the support of those who receive some benefit from its existence. Finally, it implies a form of governance in

which the state is unable to adequately interact with citizens through its institutions.

The ‘intractable circumstances’ described in Chapter 4, create vulnerabilities for Malawi’s exercise of state authority in the interests of its citizenry, reinforces the influence of an elite enclave in agenda setting for HIV/AIDs and creates the potential for the negative aspects of social forms of authority to take hold.

The Global Fund’s country level governance through its CCMs is a hybridised authority model. On the one hand it overrides socially-based authority through its bureaucratic approach based on formal institutions and impersonal rules, but it also creates a type of social authority through its elite national and transnational character. CCMs’ bureaucratic practices may discourage corruption or misuse of resources and promote the CCM as a participative forum in which state and non-state and national and international actors come together to jointly set an agenda for action, apply for Global Fund grants and oversee programme outcomes. Along these lines, Khan (2005, p. 714) argues that the role of democracy in modern developing countries is to undermine the authority of personal rule and “...[drive] the emergence of capitalism.” By depersonalising authority, opening a space for discourse beyond the state and exercising transparency, CCMs represent a substantial (or potential) counter to neo-patrimonial authority.

The authority exercised by CCMs aligns with the orthodoxy and intuitive benefits of ‘good governance’ promoted by international institutions, but it also promotes a social form of authority prevalent in the environments in which they function, in particular the elite nature of agenda setting that was observed in Malawi (see Chapter 5). As Hyden (2008, p. 17) observes:

...the basis of power in Africa is bifurcated. It is made up of, on the one hand, a small enclave-like set of actors dominated by transnational corporations and diplomats adhering to formal rules and, on the other, a myriad of relations of dependence stemming from social structures that have yet to modernize and still rely on informal institutions. There are few, if any, linkages between these two spheres which is a main explanatory factor behind Africa's lack of development.

In Malawi, the Global Fund's inclusive governance model resembles Hyden's "enclave-like set of actors", a form of authority that is bureaucratic, but also elite in nature.

According to Mason (2004, p. 2),

[t]he reconfiguration of social, political, and economic structures on a global scale loosens the container-like qualities of states, and entails a correlative shift toward global loci of authority and the legitimization of nonstate polities with domestic constituencies. At the same time, these special alterations involve the intensification of subnational forms of territorial organization.

The Global Fund's inclusive governance at country level is one manifestation of 'territorial organization' through bureaucratic authority favoured by international institutions. The CCM's emphasis on deliberation and oversight on the one hand undermines as Khan suggests patrimonial or socially-based authority which can be viewed as 'poor governance' or at worst, corruption countering the risks of weakened capacity in vulnerable states. On the other hand it replaces it with what Bull (2010, p. 221) might describe as transnational elite empowered by Mason's "legitimation of nonstate polities with domestic constituencies." The Global Fund's governance model at country level is a hybridised exercise of social authority that undermines the

patrimonial power of individual leaders and supplants it with an elite national and transnational forum.

### The Global Fund's Growing Country Level Authority: National Strategies

The Global Fund's adoption of its National Strategy Approach was argued by one Global Fund Executive to be the biggest reform in the Global Fund's history (Global Fund Executive 2009, interview, Geneva). (Malawi's failed National Strategy Application is discussed in Chapter 5). The Global Fund's board authorised the first learning wave of National Strategy Applications in 2008 (The Global Fund 2008, no page). The National Strategy Approach was part of the Global Fund's development of a health systems funding platform which was to be "country driven, results-focused and involve relevant stakeholders including civil society and the private sector" (The Global Fund 2010L p. 2) and align with IHP+ principles. The Global Fund argued that the benefits of a National Strategy Approach included more efficient processes, lower transaction costs for countries and better donor harmonisation (The Global Fund 2010L, p. 2). The rationale rested on the Global Fund's tenet of transactional efficiency.

The move to a National Strategy Approach solidifies and amplifies the Global Fund's authority at country level in two significant ways: first it explicitly expands the scope of the Global Fund's disease focused mandate to the other health MDGs for child (MDG 4) and maternal (MDG 5) health and beyond to a country's overall health system. This implies that at country level there is recognition that the Global Fund has a legitimate role in the broader health system. Second, the move to a National Strategy Approach also increases the purview of CCMs, from developing and overseeing programme-based responses to three diseases towards governing national disease strategies and health systems. This implies an expansion of the Global Fund's authority 'over' its initial



financing and agenda setting reach. The Global Fund's country level governance model is becoming a locus among government, national and international CSOs and NGOs and other donors for a much broader health agenda than was originally intended, an agenda that used to be the domain of a Ministry of Health and a Ministry of Finance.

Malawi's CCM is an example of the "bifurcation of power described" by Hyden. Its membership is drawn from "a small enclave-like set of actors" including government, the NAC, international donors and national and international NGOs and CSOs and an international private foundation. It is also a forum where "CSOs and NGOs... "compete against" each other..." (McKinsey and Company 2010, p. 37) within the context of the proposals that are developed since these organisations are often sub-recipients and implementing partners and therefore have an interest in a proposal's success and a project's design. In a review of the first National Strategy Approach 'learning wave', Malawi was among the countries which identified the process of developing a national disease strategy for HIV/AIDS as encouraging more participation from NGOs and CSOs over regular Global Fund application processes (McKinsey and Company 2010, p. 37). However, increased participation and the more comprehensive mandate under discussion were also found to amplify the "tensions in oversight between the CCM and the government accountability body [the NAC] for the national strategy particularly related to the selection and oversight of Principal Recipients [of which the NAC is one]" (McKinsey and Company 2010, p. 27). In other words, the National Strategy Approach application process increased the participation of civil society, albeit an elite selection, and further diluted the authority of government and the NAC. As one UN Executive expressed, funding national strategies is helpful because it's focusing for all partners. On the other hand, it also has the potential to be a monopoly for the Global Fund (UN Executive 2009, interview, Geneva). The process to develop Malawi's National Strategy Application to the

Global Fund is evidence that country level actors including the state accept the authority of the Global Fund to expand its scope beyond three diseases and govern the broader health agenda; moreover, the authority that the Global Fund exercises not only dilutes neo-patrimonial forms of local authority and systems of patronage it replaces it with a distinctly elite transnational form. The actors in the mediated space for country ownership have a much larger policy and service delivery remit than that for three diseases and the potential exists for a Global Fund “monopoly” or worse, an exercise of donor coercion over this new territorial claim.

Where recipient countries are concerned, the Global Fund’s expanded reach and growing authority relative to the health system overall is troubling, not because the resources and programmes are not needed, but because as discussed in Chapter 5 the Global Fund’s country level governance suffers from a double deficit in external accountability. As outlined earlier in this chapter, Malawi’s negotiations with the Global Fund to release its Rolling Continuation Channel grant disrupted the drug supply chain and caused stock outs. But more than that it heightened the CCM’s decision making role with respect to the country’s strategy for its Global Fund applications and consequently with respect to the Ministry of Health’s policy for the WHO’s 2009 treatment guidelines for HIV/AIDS:

The HIV Unit in the Ministry of Health has gone to the CCM with a technical proposal that included PMTCT (prevention of mother to child HIV transmission) based on WHO guidelines to keep mothers on treatment during breast feeding. It’s not clear why the CCM rejected this...It may not be about costs but reluctance to introduce an innovative approach. The CCM is not so transparent. It’s hard to know why exactly a technical proposal was rejected (NGO Representative 2010, interview, Lilongwe).

The lack of perceived transparency of the CCM is compounded by the perception among CCM members that the TRP's decision-making also lacks transparency.

Our experience of the National Strategy Application for Malawi with the TRP was not a positive one...[We are] interested in creating a system where the TRP maintains its independence which the Global Fund is adamant about but manages to take into account the politics and policy context of the country. I would be particularly interested in greater dialogue and representation. It seems at the moment that when a funding application goes to the TRP a decision is made behind closed doors and there is no one there to defend it. When we got our comments back on the National Strategy Application we didn't agree with them. So we went to appeal. And the TRP gave the same comments back, so there was no dialogue. For us that didn't seem to be a productive process (International CCM Member 2010, interview, Lilongwe).

If the Global Fund does move towards funding national strategies, then it begs the question as to who is in charge of health system policy making and policy implementation in a mediated space for country ownership. The Global Fund's growing authority at country level appears in Malawi's case to coincide with a weakening of government authority over the development of public health policy, amplifying the impact of the Global Fund's double deficit in external accountability.

The Global Fund's legitimacy derived from its form of institutional innovation has contributed to its authority particularly over the course of its rapid organisational maturation. The Global Fund derives its authority in part from its bureaucratic nature, its "ability to make impersonal rules" (Barnett and Finnemore 2004, p.3) underpinned primarily by its inclusive governance at global level and its transparency and performance-

based funding approach. The Global Fund's inclusion in the Health Eight and its claim to global level leadership of health systems strengthening is more than an evolution of its initial, disease-focused mandate. It is an indication that the Global Fund is recognised as a legitimate global level authority beyond HIV/AIDS, tuberculosis and malaria and a member of the global health leadership 'club'. Nevertheless, for HIV/AIDS endemic and aid reliant countries like Malawi the territorial stakes at global level mean little if treatment cannot be sustained and scale up continued.

The Global Fund's country level governance model is one manifestation of 'territorial organization' through bureaucratic authority favoured by international institutions (Mason 2004, p. 2), but one with an elite character. The CCM's emphasis on deliberation and oversight undermines socially-based patrimonial authority associated with individuals and discourages the negative aspects of this less formal form of authority, but at the same time replaces it with an elite national and transnational form. The Global Fund's adoption of its National Strategy Approach is evidence of its authority at country level and signals that the Global Fund has significantly expanded its exercise of 'authority over' compared with its initial financing and agenda setting for three diseases. The practical problem that arises is that the CCM then acquires authority traditionally held by government with none of the accountabilities expressed through democratic processes. The Global Fund's growing authority at global and country levels only serves to amplify this troubling double deficit in external accountability.

#### **4. Blurring the Boundaries and Erasing the Lines**

The Global Fund describes itself as "a unique global public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria. This partnership between governments, civil society, the private

sector and affected communities represents a new approach to international health financing” (The Global Fund 2010a, ‘About the Global Fund’). The challenge with the Global Fund’s self-described public/private partnership is that it belies the difficulty of locating authority outside of the neat boundaries of sovereignty and it obscures the dissonance that exists when loci for authority and accountability do not coincide. According to van Kersbergen and van Waarden (2004, pp. 157-8),

...the central question is whether the shifts in location of public, semi-public and private governance are threatening to make old established systems of accountability obsolete. The traditional separation of powers may be less suited to organizing accountability for these new forms of network governance.

As discussed earlier in this chapter, the Global Fund’s authority is conferred a ‘publicness’. The legitimating nature (Barker 2000, p. 9) of this ‘publicness’ and the liberal values it implies have contributed to the growth in the Global Fund’s authority ‘over’ particularly with respect to the mediated space for country ownership it has created. But as the Global Fund expands its authoritative territorial claims as evidenced at global level by its leadership of health systems strengthening and at country level by implementing its National Strategy Approach, who ‘gives’ authority and how is less clear. Without the boundaries provided by traditional liberal conceptions of state-centred, legitimate public authority, the ‘giving’ of authority evokes Stone’s (2008, p. 22) description of the global agora “... [which] encompasses a wider array of political relationships inspired by liberal democracy through to coercive arrangements of strong authoritarianism, as well as to patterns of disorder, randomness, and an absence of rational imposition of planning.” In other words the virtues associated with the Global Fund’s legitimating ‘publicness’ not only exacerbates the Global Fund’s double deficit in external accountability, but also obscures it.

Both Malawi's failed 2009 National Strategy Application and the stock outs of anti-retrovirals in 2009 and 2010 suggest that the Global Fund has taken on a "burden of responsibility" for which it is not prepared (International CCM Member 2010, interview, Lilongwe); however, its exercise of authority 'over' serves to displace this burden towards countries and to the actors in the mediated space for country ownership in two ways: first, as evident in the case of Malawi's failed National Strategy Application and the TRP's feedback on its national HIV/AIDS prevention strategy (see Chapter 5), the Global Fund's authority eclipsed that of Malawi's CCM despite its evidence-based case. Nevertheless the failure to secure funding was the CCM's and the burden of that failure--the inability to continue to scale up treatment—accrues to the 'national sphere', those actors in the mediated space for country ownership, and those whose lives are affected. Second, the case of the stock outs of anti-retrovirals in 2009 and 2010 demonstrates the failure of a number of actors in the mediated space for country ownership who were reluctant to challenge the authority of the Global Fund and the Global Fund who did nothing to address the impact of its delayed funding. When systems fail at the country level, country ownership resembles "empower[ing] these [endemic] nations to take ownership of *their* [italics mine] HIV/AIDS problem and to work to solve it" (Institute of Medicine 2010 'Sharing the Responsibility'), where the problem belongs to the country regardless of where the failures might have arisen:

Obviously we are worried, we are extremely worried. We are so dependent on the support that we get from the Global Fund, to see a situation where that is blocked in the face of increasing demand, means that the Malawi government cannot cope. They do not have the resources to manage. So I think the only plea that one can make, or the only hope that one can have, is that at least the individuals who are on treatment will continue and also the pregnant women continue to get ARVs [anti-

retrovirals] because that's one way to tackle the epidemic...the Global Fund is the only one that can do it (Health Care Worker 2010, interview, Lilongwe).

Authority then, as it is exercised by the Global Fund is evidence of “[t]he merging and blurring of lines of authority [which] are ultimately likely to blur the distinction between public legitimacy and private power” (Slaughter 2004a, p. 169). Despite its legitimating ‘publicness’, it is an exercise of authority ‘over’ where the authority ‘given’ and the accountability that goes with it remains unclear. Consequently it displaces the burden of responsibility towards the ‘national sphere’ and ultimately to the people whose lives are affected by HIV/AIDS at once both exacerbating and obscuring the Global Fund’s troubling double deficit in external accountability.

## **5. Conclusion**

When global and country level systems fail the people they are intended to serve accountability to those whose lives are affected rests close to home. This chapter has made a case for the legitimating nature of the ‘publicness’ conferred on the Global Fund’s authority and the dissonance this creates between loci for authority and accountability. It tracks the Global Fund’s rapid rise in authority at both global level as evidenced by its claim to leadership in health systems strengthening and at country level as evidenced by its National Strategy Approach. These territorial claims, far beyond the Global Fund’s original remit as a financing mechanism for three diseases, have gone largely unchallenged even though the Global Fund’s double deficit in external accountability makes clear that the Global Fund may not be set up for the extent of its burden of responsibility.

Finally the chapter argues that the legitimating nature of the ‘publicness’ conferred on the Global Fund’s authority and its rapid expansion exacerbates and obscures its weak authority-external accountability link. As Malawi’s failed 2009 National Strategy

Application and the anti-retroviral stock outs in 2009 and 2010 indicate, although the Global Fund has taken on a burden of responsibility far beyond its original remit, when global and country level systems fail, this burden is displaced towards the ‘national sphere’—those in the mediated space for country ownership and those whose lives are affected by HIV/AIDS. The powerful effects of the Global Fund’s authority ‘over’ means that country ownership may be less about the empowerment of agenda setting and citizen participation as it is about owning the problem at hand, particularly when failures occur. The model that is emerging is one where the Global Fund has increasing authority and diminishing external accountability to those whose lives it affects. The “new global public domain” (Ruggie 2004, p. 519) needs an accountability model beyond one that serves wealthy and powerful states.

...contemporary multilateral institutions...are contingently legitimate...But their advocates, and their leaders, should begin to reconstruct their legitimacy on a 21st century basis – with more emphasis on democratic principles and less on sovereignty. Otherwise, multilateral institutions will be in danger of losing legitimacy to a revival of democratic nationalism, or to new forms of transnational organization that are designed to bypass sovereignty, and that will be in many ways problematic for those of us who believe in the accountability of power-wielders to ordinary people (Keohane 2006, p.23).

Returning to the stock outs of anti-retrovirals that occurred in Malawi in 2009 and 2010, it is clear that the system of Global Fund financing and the global and country systems that managed the drug supply chain failed; moreover, there was no mechanism, no course of action for those affected to hold those responsible to account. Until a new order emerges from Kirton and Cooper’s (2009, p. 309) “Westphalian order of old”, the people affected by HIV/AIDS are left vulnerable, “...unhappy and doubtful about how things will



continue--that maybe one day the medicine will not be there” (Health Care Worker 2010, Interview, Zomba). To experience, as Rosenau (1995, p. 13) suggests “hope embedded in despair”, requires that the Global Fund comes to terms with its burden of responsibility and recognises and resolves what is a troubling and obscured dissonance between the loci for authority and accountability.

## **Chapter 7 - Conclusions, the Global Fund's Agenda for Reform and Future Research**

### **1. Conclusions**

This thesis is an inquiry into change, both organisational and systemic, that arises from the creation of the Global Fund. The puzzle at its centre seeks to understand how the Global Fund has so rapidly won legitimate authority at global and country levels even though the nature of its innovative design challenges liberal notions of legitimate state authority in the international system. The thesis argues that the Global Fund has become more than a financing mechanism to address MDG 6. It is a new type of international institution which at global level has disrupted the traditional multilateral order and is shaping a new order that is emerging. At country level, it has created a mediated space for country ownership from which a troubling double deficit in external accountability has arisen. The case of Malawi's failed 2009 National Strategy Application shows that while country ownership as it is advocated by the Global Fund may imply Malawi's ownership of its HIV/AIDS agenda, this falls away when global politics and country evidence collide. The stock outs of anti-retrovirals in Malawi in 2009 and 2010 underscore the burden of responsibility that accrues to the 'national sphere' regardless of where the failures occur, suggesting that the Global Fund may not be set up to govern the scope of authority it has claimed. The nature of this authority, its legitimating 'publicness', its exercise 'over' ultimately by wealthy and powerful states and its rapid expansion at global and country levels serves to both exacerbate and obscure the Global Fund's double deficit in external accountability. The Global Fund's form of institutional innovation and its departure from the well defined boundaries of the realist-positivist idea of legitimate authority centred on the nation state

signifies that the new order which is emerging comes with a troubling dissonance between loci for authority and accountability which has yet to be resolved.

Two research questions shaped this thesis. The first asked how the Global Fund has changed global health governance and what the implications are for traditional multilateralism, particularly its sources of legitimacy, authority and accountability.

Chapters 2 and 3 set out the analysis and response. First, in Chapter 2 the thesis argues that the Global Fund is a form of institutional innovation within the traditional multilateral order. It lays out “a confluence of events” which served as the crucible from which the Global Fund emerged. These events included a political and discursive case for change advocated by wealthy and powerful states and the availability of new sources of funds from donor governments and private actors to address HIV/AIDS, tuberculosis and malaria. Together with the UN’s desire to embrace private actors and the virtues attributed to a neo-liberal ethos, these events informed the Global Fund’s unique design.

Chapter 2 introduces the aspects of the Global Fund’s design which lend it its institutionally innovative character. These are its inclusive governance model at both global and country levels, its transparency and performance-based funding approach and the scale of its resource mobilisation and distribution. The chapter also describes its initial vertical disease focus. Subsequent chapters link the Global Fund’s organisational maturation to its departure from this initial, vertical mandate. They also examine how these design features have both legitimised and catalysed the Global Fund’s rapid growth in authority which heighten its troubling double deficit in external accountability.

Chapter 2 argues that the Global Fund’s institutionally innovative design has challenged the leadership and division of labour among multilaterals and international health institutions including the WHO, UNAIDS, UNDP, the World Bank, Roll Back Malaria and

Stop TB and as a consequence the Global Fund has disrupted the traditional multilateral order, particularly where health is concerned. The evidence provided is three fold: first the Global Fund has gained momentum towards becoming a global level policy maker; second it has created an ‘unfunded mandate’ for many traditional international health institutions at country level; and lastly, the Global Fund has changed the nature of competition for donor resources. Therefore, in investigating how the Global Fund has changed traditional multilateralism, the thesis contends that its institutional innovation is the foundation for its disruptive effects on the traditional multilateral order where international health institutions are concerned and its shaping of the order that is emerging.

Chapter 3 builds on this global level analysis by arguing that the Global Fund’s design has provided new sources of legitimacy which are linked to and therefore have implications for its accountability mechanisms. It asserts that the Global Fund’s legitimacy is not what Scharpf (1999, p. 2) defined as ‘input-oriented’ as it may first appear and as the legitimating effects of its inclusive governance and transparency practices might suggest, but rather it is ‘output-oriented’--strongly focused on donor governments and the necessity of ‘proving’ its outcomes and accomplishments. In other words the Global Fund’s legitimacy reinforces its resource mobilisation function. In addition, because the Global Fund’s legitimacy is held in the eyes of donor governments, its accountability model is internally oriented. That is, it forms a hierarchical chain of accountability that ultimately accrues to donor governments rather than to those whose lives the Global Fund affects. Consequently, the Global Fund is subject to donor influence and in particular influence from its largest donor, the United States which has signalled that its interests have transitioned from supporting an emergency HIV/AIDS response to an agenda of efficiency, effectiveness and country responsibility. The disparity between country responsibility or ownership and country authority is described in Chapter 5 which sets out the Global

Fund's double deficit in external accountability in relation to Malawi's failed 2009 National Strategy Application and its associated HIV/AIDS prevention strategy. It is also discussed in Chapter 6 where Malawi's stock outs of anti-retrovirals in 2009 and 2010 add to the evidence that the burden of responsibility when failures occur accrues to the 'national sphere', and is ultimately borne by those who Stiglitz (1998, p. 21) described as the "often-excluded."

Chapters 2 and 3 respond to the first research question. They make a case for the Global Fund's design as a form of institutional innovation within the traditional multilateral order, one that has had disruptive effects. They analyse the Global Fund's new sources of legitimacy and make the link to its internally focused accountability model. Consequently, the research and analysis in these chapters provides a basis to evolve the IR literature on globalisation, governance and international institutions to consider the nature, significance and effects of the Global Fund beyond its characterisation as a financing mechanism for three diseases. It positions the Global Fund as an international institution worthy of the attention of IR scholars, one that is shaping the order which is replacing "the Westphalian order of old" (Kirton and Cooper 2009, p. 309).

The second research question for this thesis asked how the Global Fund's governance has affected what is 'country owned' with respect to Malawi's HIV/AIDS response and in particular Malawi's HIV/AIDS prevention strategy and what the implications are for accountability to those whose lives are affected. Chapter 4 provides an empirical analysis of Malawi's intractable political, economic and social circumstances including its HIV/AIDS epidemic. It also describes the structure and nature of Malawi's health system and its HIV/AIDS response. It challenges the proposition that a new aid architecture is emerging where Malawi's ownership of its development agenda and funding tied to

performance are in evidence. Rather, it asserts that Malawi's aid dependence and its reliance on and vulnerability to its Global Fund relationship in order to respond to its devastating HIV/AIDS epidemic is a lot like the aid architecture--and by implication the donor/recipient country relationships--of old.

Chapter 5 explores 'country ownership' in more depth. It begins by tracing the roots of the term 'country ownership' as an antidote to the negative connotations of 'IFI ownership' associated with the legacy of structural adjustment. It argues that in practice, the liberal ideals of citizen participation may be naïve particularly where "...elite control of the state systems ensures their access to both the dwindling economic opportunities and the mechanism for state power...ensuring that economic and political privilege are protected" (Poku and Sandkjaer 2007, p. 12). It outlines how the Global Fund's CCM model creates a mediated space for country ownership where 'country' includes elite actors beyond the state, both national and international. Further, it's not the force of technocratic efforts to effect a new 'country ownership' aid architecture which shapes this space in Malawi, but rather the old-fashioned donor/recipient power asymmetry between the Global Fund's resources, Malawi's aid reliance and its long term arc of need. It argues that these dynamics layered with the Global Fund's internal accountability model exacerbate the Global Fund's accountability gap, giving rise to a double deficit in external accountability: no mechanism exists to hold the Global Fund created mediated space for country ownership nor the Global Fund and its organs to account to Malawians affected by HIV/AIDS.

As the case of Malawi's failed National Strategy Application and the feedback from the TRP on Malawi's accompanying HIV/AIDS prevention strategy points out, 'country ownership' may be advocated by the Global Fund, but it fails when global politics and

country evidence collide. At country level, the ‘giving’ of authority by wealthy and powerful states to recipient countries over their problems and the ‘giving’ of authority by ‘national publics’ to the Global Fund over agenda setting creates a dissonance between the loci for authority and accountability. This argument is revisited in Chapter 6 in relation to the rapid rise in the Global Fund’s authority and both global and country levels.

Chapters 4 and 5 offer research and analysis related to the second research question. They offer new insight for scholars and practitioners related to the governance problems that arise when the political interests at global level conflict with the agenda set at country level in a Global Fund convened mediated space for country ownership. The research provides evidence for challenging the implied and ambiguous use of the term ‘country ownership’ to mean the ‘country is in the driver’s seat’ to one where country takes on a broad interpretation beyond the state and ownership relates to the problem as much as the agenda that shapes the solution.

This inquiry provides a ‘thick’ description in response to the two research questions that shaped it. Chapter 6 synthesises the arguments for the Global Fund as an agent of change at global and country levels. It examines the nature of the Global Fund’s authority including the contrast that exists between its legitimating ‘publicness’ and its more coercive exercise ultimately by wealthy and powerful states in a traditional donor/recipient relationship. It links the Global Fund’s organisational maturation and with its rapidly growing authority at global level as evidenced by its claim to leadership in health systems strengthening. It links its creation of a mediated space for country ownership with its rapidly growing authority at country level as evidenced by its National Strategy Approach. It makes the case that the nature of the Global Fund’s authority, its legitimating ‘publicness’, its exercise of authority ‘over’ by wealthy and powerful states and its rapid

expansion at global and country levels serves to exacerbate and obscure its external accountability problem. It concludes by observing that the dissonance between loci of authority and accountability remains unresolved.

## **2. The Global Fund's Agenda for Reform**

The Global Fund's direction is evidence of its strong alignment with the United States' interest in efficiency, effectiveness and country responsibility (see Chapter 2). At its 23<sup>rd</sup> Board Meeting in May 2011, the Global Fund's board endorsed the proposal from the Comprehensive Working Group on Reform which among other items set forth the direction for its business model and governance (The Global Fund 2011f, 'Twenty-Third Board Meeting'). The reforms acknowledge the Global Fund's authority and influence, advocating that it "leverage its role as a predominant financier of essential health products to help shape the markets for those products so as to improve price, quality, design and sustainable supply, and as a result, health outcomes" (The Global Fund 2011d, p. 14). The Global Fund's market role extends its authority beyond the global and country health policy domain as discussed in this thesis and further "blur[s] the distinction between public legitimacy and private power" (Slaughter 2004a, p. 169).

The Global Fund's reforms to its business model and governance do not recognise or aim to address the dissonance between its growing authority and its double deficit in external accountability. In fact they work to do the opposite--strengthen the Global Fund's internal, hierarchical accountability oriented towards wealthy and powerful states. For example, the principles which are to guide its business model include focusing on disease impact and value for money, adjusting its resource allocation relative to performance and risk of the grant, the Principal Recipient and the country, and the size of its overall country investment, and lastly measuring its effectiveness with respect to health impact and



transaction costs (The Global Fund 2011d, p. 17). The value for money agenda reverberates strongly, with the Global Fund indicating its interest in “moving towards payment-for-service” (The Global Fund 2011d, p. 17). Its governance reforms focus exclusively on improving the effectiveness of its board, with the exception of one objective which is to “[r]eview role [sic] and oversight of the TRP and Partnership Forum, with a focus on aligning the role, processes, and structure of the TRP to the Global Fund’s reform agenda and the 2012-16 strategy, and increasing the efficiency and impact of the Partnership Forum” (The Global Fund 2011d, p. 17). In other words, reform of country level governance and addressing external accountability is not a concern, but donor interests in efficiency, effectiveness and the mantra of value for money are.

The Global Fund was the international community’s response to the HIV/AIDS pandemic after 20 years of inaction. From the point of view of its initial mandate as a financing mechanism for three diseases it has mobilised and distributed funds of a magnitude that has helped countries like Malawi make progress in fighting a devastating epidemic. It has however, over its relatively short institutional history, grown its authority and become pivotal to a burden of responsibility for which it was never designed. As this thesis points out, when failures occur and lives are affected, there are no external accountability mechanisms that hold either the Global Fund created mediated space for country ownership to account or the Global Fund and its organs. The emerging order which is replacing the ‘Westphalian order of old’ has so far failed to acknowledge or resolve its troubling weak authority-accountability link.

### **3. Future Research Suggestions and Caveats**

As described in Chapter 1, the descriptive, single case study approach adopted for this thesis provides several avenues for future research and inquiry, rather than a basis for generalised findings. This future research and inquiry has five distinct facets:

1. The first is to develop comparative country studies on the Global Fund's effects on the mediated space for country ownership. There are a number of studies which compare country level institutional models related to the Global Fund (for example, Dickinson, Mundy and Whitelaw Jones 2007; Dickinson and Druce 2010), but they largely provide an empirical account of who does what rather than further a scholarly analysis of the Global Fund's governance gap related to authority and accountability. A more traditional comparative country study design could analyse 'like' situations for example among countries in sub-Saharan Africa or 'unlike' situations, for example assessing the differences between low and middle income countries or types of epidemics.
2. The second relates to the governance of country HIV/AIDS prevention strategies. With infections continuing to increase in some countries, limited or constrained donor resources and the challenge of the 'treatment mortgage' the dissonance between 'country ownership' of prevention and the loci for accountability and authority deserves further exploration. There is a contribution to be made to better understand the political and social aspects of the governance of HIV/AIDS prevention strategies, and a necessity to complement analysis that is largely situated in a biomedical and health systems implementation domain.
3. Third there is a more normative exploration on accountability mechanisms that address or at least could alleviate the external accountability gap particularly in sectors where new institutional models are emerging. For example the area of

climate change or rapidly adapting sectors such as mobile telephony where the lines of public legitimacy and private power may blur. This could provide instructive positive or problematic examples of innovative accountability mechanisms and a basis to evolve the Global Fund's governance model so that it is reflective of the Global Fund's burden of responsibility.

4. The fourth concerns the interplay between the Global Fund and its partners beyond the Global Fund's disruptive effects, particularly in relation to UNAIDS deserves some attention. UNAIDS' 2011-2015 strategy, *Getting to Zero* (UNAIDS 2010a, 'Getting to Zero') highlights three priorities: to revolutionise HIV/AIDs prevention, to catalyse the next phase of treatment, care and support and to advance human rights and gender. The extent to which the Global Fund is politically and practically prepared to share and support these priorities has significant implications for UNAIDS. Research related to the inter-organisational requirements and optimal organisational structures to enhance cooperation, small 'p' politics and performance and incentive mechanisms to align global leadership on effective strategy and implementation could assist these organisations and their boards in improving their effectiveness and efficiency and better serving their beneficiaries.
5. Lastly, where the effects of the double deficit in external accountability are concerned, there is opportunity for more local research. This would isolate the critical factors that contribute to it, particularly in the mediated space for country ownership, the nature and magnitude of its effects and normative strategies to resolve it.

The ‘thick description’, single case study method adopted for this thesis has its limitations (see discussion and rationale in Chapter 1) the main one being that generalisations are not possible. However, the research process uncovered a number of avenues for future research, some of which could adopt a more traditional comparative case study method, and others which have a normative nature. Both are necessary to better understand the Global Fund’s effects as a change agent within the traditional multilateral order and in global and country level health governance. The speed with which the Global Fund has both matured and adapted challenges scholars to set a pace of inquiry that has so far lagged

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## Endnotes

<sup>1</sup>The Millennium Development Goals were adopted in September 2000 by the 189 member states of the United Nations. They set out eight development priorities for donor and recipient governments and are a mechanism to focus and measure progress against targets for 2015 (UN 2000b, 'UN Millennium Declaration').

<sup>2</sup>IPPPH ceased operations in 2004 and the database is not currently publicly available.

<sup>3</sup>The literature on public goods and global public goods is extensive. For public goods and global public goods see: Sandler (1992). For global public health as a global public good see Chen, Evans and Cash (1999), Sandler and Arce M. (2002), and Kaul and Pedro Conceição (2006a). On the provision of global public goods including their private provision see Kaul, Conceição, Le Goulven, and Mendoza (2003) and Conceição (2003). On the role of international institutions in the provision of global public goods see Zedillo and Thiam (2006).

<sup>4</sup>See Kaldor (2003, pp. 589-90) and Keane (2003, p. 8 and p. 64).

<sup>5</sup>In other efforts to engage the private sector the UN established the United Nations Office for Partnerships in 1998 to serve as "a gateway for collaboration between the private sector, foundations, and the United Nations family (United Nations Office for Partnerships 2011, 'About Us')" and in 2000 it launched the Global Compact intended to promote the alignment by businesses with the "ten universally accepted principles in the areas of human rights, labour, environment and anti-corruption" (United Nations Global Compact 2011, 'About Us').

<sup>6</sup>Of the 48 Global Health Initiatives analysed for this study, 21 of them included the Bill and Melinda Gates Foundation among their funders and/or governors.

<sup>7</sup>Analysis by author based on grant portfolio data extracted from the Global Fund's website. Accessed November 10, 2010.

<sup>8</sup>Simply, parallel importing refers to the ability to buy drugs at a cheaper price outside a country and import them. The literature on parallel imports largely focuses on the political economy of trade and the WTO. See for example Sykes (2002).

<sup>9</sup>The Global Fund was initially constituted as a private foundation but became an international institution in 2004. This is discussed in more detail later in this chapter.

<sup>10</sup>The Transitional Working Group, comprised of representatives of developing countries, donor countries, NGOs, the private sector, and the UN system, developed guidelines for the Global Fund's operation, including its legal status, management structure, financial systems and eligibility criteria (The Global Fund 2010p, 'Transitional Working Group').

<sup>11</sup>The Global Fund concluded a Headquarters Agreement with the Swiss Government in 2004. It does not provide the Global Fund treaty making capacity or the capacity to espouse international claims. In assessing its options for changing its legal status, the Global Fund noted, "According to internal [sic] law, the Global Fund in its present status would not qualify for an agreement with the Swiss government, such as that provided to the International Federation of the Red Cross and Red Crescent Societies, which did not require treaties to initiate their international status. The transformation of the Global Fund into an intergovernmental organization would require the conclusion of a multilateral

treaty. The conclusion of a headquarter agreement between the future IO and the host State is relatively easy in Switzerland” (The Global Fund to Fight AIDS, Tuberculosis and Malaria 2003, p. 5).

<sup>12</sup> The WHO Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR) are examples. See Fidler (2007). For the FCTC see Collin and Lee (2009). For the IHR see Sridhar, Khagram and Pang (2008).

<sup>13</sup> Artemesin is marketed as Coartem by Novartis. It is an anti-malarial medication that is effective on a type of malaria parasite for which chloronique is no longer effective.

<sup>14</sup> The Headquarters Agreement with the Swiss Government does not provide the Global Fund treaty making capacity or the capacity to espouse international claims. The Headquarters Agreement provides the Global Fund with certain privileges and immunities available to international organisations (i.e. certain legal immunities and exemption of its assets, income and other property from direct federal, cantonal and communal taxes), without entering into a multilateral treaty.

<sup>15</sup> Analysis by author based on pledge data extracted from the Global Fund’s website. Accessed February 17, 2010.

<sup>16</sup> This is not to say that monitoring and evaluation of vertically-focused disease programmes in high need countries with weak infrastructures is in any way straightforward or not without significant challenges. As the Global Fund’s Five-Year Evaluation noted in its study of the outcomes of Global Fund investment in 18 countries, “[n]otwithstanding these positive developments [important improvements in data availability], the evaluation study found significant deficiencies in data availability, quality, and comparability both at baseline and over time (Macro International 2009, p. ES8).

<sup>17</sup> President Mutharika died suddenly in office in April 2012 and was succeeded by his Vice President, Joyce Banda.

<sup>18</sup> In 2011, subsequent to field research for this thesis, the international community expressed concern over President Mutharika’s exercise of authority. In April 2011, Malawi expelled Britain’s High Commissioner after a leaked diplomatic cable in which he called the country’s government autocratic. In July, Britain suspended aid and later the same month 18 people were reported killed and 200 arrested in demonstrations against the government (The Guardian, July 14 2011 and July 22 2011).

<sup>19</sup> The Vision 2020 process was undertaken by Malawi’s National Economic Council. A core group comprised of representatives from government, the private sector and academia managed the process which was supported by a working group that included representatives from chiefs, trade unionists, civil servants, parliamentarians, womens’ groups, the police, army and others. The process included analytical working papers, scenario planning and public consultations and conferences (Government of Malawi (1997), ‘Malawi Vision 2020 Mission Statement’).

<sup>20</sup> Malawi devalued the kwacha during this period. The 1994 exchange rate applied is 0.224724 and the 2008 exchange rate applied is .00723306.

<sup>21</sup> This figure is significantly lower than the estimate provided in the Malawi Health SWAp Mid-Term Review, which provides a figure of US\$20 of funding for the health SWAp in 2004/05 which includes all sources, public and private (Carlson et al. 2008b, p. 25 and p.220).

<sup>22</sup> Assumes the population of Malawi is 12.75 million and the rate exchanging the Malawi Kwacha to the US\$ is 134.74.

<sup>23</sup> Professor Tony Harries had worked in Malawi for over 20 years when he led the first scaled up HIV/AIDS response in Malawi for what was then the HIV Unit at the Ministry of Health and Population.

<sup>24</sup> These projections did not take into account Malawi's two failed Global Fund grant rounds. As discussed later in this chapter, the first was its 2009 National Strategy Application and the second was its Round 10 application, both focused on HIV/AIDS. In addition Malawi faced donor sanctions in 2011.

<sup>25</sup> Analysis by author based on Global Fund Grant Performance Reports.

<sup>26</sup> The term "national ownership" is used interchangeably with "country ownership." For example, the final report of UNAIDS' Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (which included the Global Fund) notes that national or country ownership refers to "a broad-based partnership, encompassing government, civil society (including people living with and affected by HIV), the private sector, academic institutions, and others" (UNAIDS 2005a, p. 11). The point made in this paragraph is that the specificity of what is meant by national (or country) was not evident in the Global Fund's Framework Document.

<sup>27</sup> Men having sex with men (MSM) is an epidemiological term which does not reflect how men self-identify as either homosexual or bisexual.

<sup>28</sup> Evidence-based here is used in its epidemiological sense. It is not intended to signal debates on what constitutes evidence and how this shapes and distorts policy development.

<sup>29</sup> Malawi's Round 10 application to the Global Fund subsequently proved unsuccessful.

# Appendices

## 1. Research Plan Excerpt: Propositions and Rival Propositions

Connecting Propositions (and Rival Propositions), Data and Information Sources and Literatures		
Proposition	Data and Information	Literatures (cumulative list)
<p>Describe how the Global Fund as a form of institutional innovation within traditional multilateralism has affected global health governance:</p> <p><u>Unit of Analysis:</u> Global health governance for HIV/AIDS, malaria and tuberculosis among the following organisations:</p> <p>The Global Fund WHO UNAIDS Roll Back Malaria (RBM) Stop TB</p>		
<p>While the clarification of leadership roles among global partners relative to the three diseases and health systems strengthening may have improved, there remain gaps at global level where ‘theory’ and ‘practice’ do not align.</p> <p>Alternatively, the global governance of health is supported by clear leadership roles among global partners in theory and practice.</p>	<ul style="list-style-type: none"> <li>• Current by-laws and governance documentation</li> <li>• Key informant interviews (targeting people in governance, partnership and/or programme roles)</li> </ul>	<ul style="list-style-type: none"> <li>• Multilateralism</li> <li>• Global governance (general)</li> <li>• Global health governance</li> <li>• Public-private partnerships</li> </ul>
<p>The emergence of the Global Fund since 2002 has contributed to changes in the division of labour among global partners with some exercising more authority over and influence in particular disease areas and others less.</p> <p>Alternatively, despite the emergence of the Global Fund there has been little change in the division of labour among global partners.</p>	<ul style="list-style-type: none"> <li>• Mandates, strategic evaluations from 2002 to 2008</li> <li>• Policy documents in the global public health literature (examples – not an exhaustive list):</li> <li>• World Health Organization (1978) ‘Declaration of Alma</li> <li>• World Bank (2003) <i>World Development Report 1993: Investing in Health</i></li> <li>• Report of the Commission on Macroeconomics and Health (2001) <i>Macroeconomics and Health: Investing in Health for Economic Development</i></li> <li>• McKinsey (2005) <i>Global Health Partnerships:</i></li> </ul>	<ul style="list-style-type: none"> <li>• Global public health policy</li> <li>• Global public goods</li> <li>• Health systems strengthening</li> </ul>



Connecting Propositions (and Rival Propositions), Data and Information Sources and Literatures		
Proposition	Data and Information	Literatures (cumulative list)
	<p><i>Assessing Country Consequences</i></p> <ul style="list-style-type: none"> <li>• Report of the International Task Force on Global Public Goods (2006)</li> <li>• <i>Meeting Global Challenges: International Cooperation in the National Interest</i></li> <li>• Etc.</li> <li>• Key informant interviews</li> </ul>	
<p>The Global Fund in particular has influenced the public global health policy discourse through its strategy and funding.</p> <p>Alternatively, the Global Fund has had little influence on the global public health policy discourse compared to other global partners.</p>	<ul style="list-style-type: none"> <li>• Global Fund Board decisions and documents</li> <li>• Task force and committee reports among the organisations listed above</li> <li>• Global Fund calls for proposal and funded applications</li> <li>• Global public health discourse as above</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<p>The Global Fund in particular has influenced the resource mobilisation strategies of global partners.</p> <p>Alternatively, resource mobilisation strategies of global partners have changed little since 2002.</p>	<ul style="list-style-type: none"> <li>• Where available, regular and special budgets from 2002 to 2008</li> <li>• Key reports and policy documents on global aid architecture</li> <li>• OECD DAC (2005). The Paris Declaration.</li> <li>• OECD DAC (2008b). The Accra Agenda for Action.</li> <li>• Sachs, Jeffrey (2005). Investing in Development – A Practical Plan to Achieve the Millennium Development Goals. UN Millennium Project Report to the UN Secretary-General</li> <li>• Etc.</li> <li>• Key informant interviews</li> </ul>	<ul style="list-style-type: none"> <li>• Aid architecture (The Global rather than country)</li> <li>• Global Civil Society</li> <li>• Aid architecture</li> </ul>
<p>To describe how the Global Fund's resources and governance have affected what is 'country owned' with respect to Malawi's HIV/AIDS response and in particular Malawi's HIV/AIDS Prevention Strategy and what are the implications for accountability to those whose lives are affected</p> <p><u>Unit of Analysis:</u> The country level effects of Global Fund resources and governance, particularly agenda setting for HIV/AIDS</p> <p><u>Key Informant Interviews:</u></p> <p>Members of the Global Fund's Country Coordinating Mechanism (CCM)</p> <p>Decision makers, influencers and those involved in researching, developing, leading or implementing health human resource strategies for HIV/AIDS (which also include CCM members):</p>		

Connecting Propositions (and Rival Propositions), Data and Information Sources and Literatures		
Proposition	Data and Information	Literatures (cumulative list)
National AIDS Commission MoH, MoF Donors that pool funds (e.g. WB, DfID, NORAD, UNFPA, and formerly CIDA) Donors that don't pool funds (e.g. UNDP, USAID, CDC) NGOs (e.g. MSF) UN organisations – WHO, UNAIDS Foundations (e.g. Clinton)		
Aligning and Coordinating Donors and Partners: The Global Fund's country governance model serves to align and coordinate country partners' agenda setting and resource mobilisation for the HIV/AIDS response Alternatively, the Global Fund's country governance model fragments alignment and coordination among country partners involved agenda setting and resource mobilisation for the HIV/AIDS response	<ul style="list-style-type: none"> <li>Global fund proposals and reports (Round 1 HIV/AIDS, Round 5 HIV/AIDS, Round 5 Health Systems Strengthening)</li> <li>Research reports on the Global Fund's impact on Malawi</li> <li>National HIV/AIDS Strategy</li> <li>National HIV/AIDS Prevention Strategy</li> <li>National HIV/AIDS Framework</li> <li>Health SWAp mid-term review</li> <li>SWAp donor group needs assessment (2007)</li> <li>Etc.</li> <li>Key informant interviews</li> </ul>	<ul style="list-style-type: none"> <li>Health policy literature (country level)</li> </ul>
Scaling Up the HIV/AIDS Response: The Global Fund, as the largest funder of the HIV/AIDS response in Malawi, has had the greatest influence over agenda setting for the HIV/AIDS response and Prevention Strategy Alternatively, regardless of the scale of Global Fund's financial contribution, other actors have legitimately led agenda setting for the HIV/AIDS response and Prevention Strategy	<ul style="list-style-type: none"> <li>As above</li> </ul>	<ul style="list-style-type: none"> <li>As above</li> </ul>

## 2. Interview Question Example: Geneva-based Interview

Theme	Proposed Questions
<b>Global Partners – Current Leadership</b>	<ol style="list-style-type: none"> <li>1) Among global partners today, how would you describe the Global Fund's leadership role in combating HIV/AIDS, malaria and tuberculosis?</li> <li>2) Among global partners today, what is your view of who leads what with respect to combating HIV/AIDS, malaria and tuberculosis?</li> <li>3) At global level today, can you describe an example where a global partner is particularly effective at leading some aspect of combating HIV/AIDS, malaria or tuberculosis?</li> </ol>
<b>Global Partners – Division of Labour</b>	<ol style="list-style-type: none"> <li>1) Since its creation, how has the Global Fund affected—if at all--the division of labour among global partners?</li> <li>2) Since its creation, how has the Global Fund affected—if at all--which global partners have authority over and influence on global public health policy?</li> <li>3) Can you describe an example?</li> </ol>
<b>Global Public Health Policy Discourse</b>	<ol style="list-style-type: none"> <li>1) In your opinion, since its creation has the Global Fund influenced the global public health policy discourse?</li> <li>2) If so, how?</li> <li>3) If not, why not?</li> </ol>
<b>Global Partners – Resource Mobilisation</b>	<ol style="list-style-type: none"> <li>1) The Global Fund has mobilised significant resources since 2002 for MDG 6. In your view, how has this affected the resource mobilisation strategies of other global partners?</li> <li>2) What in your view is the relationship—if any—between leadership at global level and resource mobilisation at global level?</li> </ol>
<b>Global Fund Influence on Country Public Health Policy</b>	<ol style="list-style-type: none"> <li>1) Generally, in your view, how has the Global Fund influenced—if at all—country public health policy?</li> <li>2) Can you describe an example (Uganda, Tanzania)?</li> <li>3) How is the Global Fund's influence different from or similar to other aid providers?</li> </ol>
<b>Global Fund Influence on Country Healthcare Professionals</b>	<ol style="list-style-type: none"> <li>1) How, in your view, has the Global Fund affected—if at all—country policies, strategies or practices related to attracting and retaining healthcare professionals in the three disease areas?</li> <li>2) Can you describe an example (Uganda, Tanzania)?</li> <li>3) How is the Global Fund's influence in this regard different from or similar to other aid providers?</li> </ol>
<b>Additional Questions</b>	<ol style="list-style-type: none"> <li>1) How does the Global Fund determine, internally and with partners, its</li> </ol>

Theme	Proposed Questions
	<p>priorities for each funding round?</p> <p>2) How did Global Fund's and GAVI's leadership role in HSS among IHP+ partners emerge?</p> <p>3) What is the future of 'innovative financing' mechanisms? How do they affect the politics of aid?</p>

### 3. The Millennium Development Goals (MDGs)

The Millennium Development Goals (MDGs) were laid out in the United Nations

Millennium Declaration (UN 2000b, 'UN Millennium Declaration'):

Goal	Targets
<b>Goal 1 - Eradicate extreme poverty and hunger</b>	Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day Halve between 1990 and 2015, the proportion of people who suffer from hunger
<b>Goal 2 – Achieve universal primary education</b>	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.
<b>Goal 3 – Promote gender equality and empower women</b>	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015
<b>Goal 4 – Reduce child mortality</b>	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
<b>Goal 5 – Improve maternal health</b>	Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate
<b>Goal 6 – Combat HIV/AIDS, malaria, and other diseases</b>	Have halted by 2015 and begin to reverse the spread of HIV/AIDS Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
<b>Goal 7 – Ensure environmental sustainability</b>	Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers
<b>Goal 8 – Develop a Global Partnership for Development</b>	Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system (includes a commitment to good governance, development and poverty reduction—both nationally and internationally) Address the special needs of the Least Developed Countries (includes tariff- and quota-free access for Least Developed Countries' exports, enhanced program of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt, and more generous official development assistance for countries committed to poverty reduction) Address the special needs of landlocked developing countries and small island developing states (through the Program of Action for the Sustainable Development of Small Island Developing States and 22 <sup>nd</sup> General Assembly provisions) Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term In cooperation with developing countries, develop and implement strategies for decent and productive work for youth In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries In cooperation with the private sector, make available the benefits of

Goal	Targets
	new technologies, especially information and communications technologies

#### 4. Comparing the WHO's Constitution and the Global Fund's By-laws

	<b>World Health Organization (WHO) - Constitution<sup>30</sup></b>	<b>The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) By-laws<sup>31</sup></b>
<b>Instrument and Date</b>	Constitution  Original signed July 1946	By-laws  Adopted January 2002
<b>Organisation type</b>	Specialised agency of the United Nations	Non-profit foundation under (Switzerland) – Headquarters Agreement in 2004 changed status to an international organisation
<b>Membership</b>	All states	Members of the Board representing their constituencies including donor and recipient governments and international and country level NGOs and CSOs
<b>Governance bodies</b>	<ol style="list-style-type: none"> <li>1) World Health Assembly (WHA) <ol style="list-style-type: none"> <li>a) Delegates representing members (one member = one vote) Determines policy</li> <li>b) Can establish regional organisations</li> </ol> </li> <li>2) Executive Board <ol style="list-style-type: none"> <li>a) 34 persons designated by members</li> <li>b) Executes WHA decisions and policies</li> <li>c) Can establish committees at the direction of the WHA</li> </ol> </li> <li>3) Secretariat <ol style="list-style-type: none"> <li>a) Director-General and technical and administrative staff</li> </ol> </li> <li>4) Regional Organisations <ol style="list-style-type: none"> <li>a) Comprised of a regional committee (members) and a regional office</li> <li>b) Formulate regional policy</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1) Global Level Board <ol style="list-style-type: none"> <li>a) Originally 18 voting members (7 developing country, 7 donors, 4 civil society/private sector),</li> <li>b) 4 non-voting members (1 NGO-person or community living with AIDS, TB or malaria, WHO, UNAIDS, Trustee)</li> </ol> </li> <li>2) Evolved to: <ol style="list-style-type: none"> <li>a) 20 voting members = 7 developing country members, 8 donors, 5 civil society/private sector)</li> <li>b) 6 non-voting members = WHO, UNAIDS, Trustee, Swiss Citizen, Executive Director, Partners Constituency (Stop TB, Roll Back Malaria and UNITAID)</li> <li>c) Sets policies and strategies</li> </ol> </li> <li>2) Secretariat <ol style="list-style-type: none"> <li>a) Manages day to day operations</li> </ol> </li> <li>3) Technical Review Panel <ol style="list-style-type: none"> <li>a) Independent and impartial advisors appointed by the Board</li> </ol> </li> </ol>

	<b>World Health Organization (WHO) - Constitution<sup>30</sup></b>	<b>The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) By-laws<sup>31</sup></b>
		<ul style="list-style-type: none"> <li>b) Reviews applications and makes recommendations to the Board</li> <li>c) No specific membership defined</li> </ul> <p>4) Partnership Forum</p> <ul style="list-style-type: none"> <li>a) A periodically (every 24 – 30 months) convened forum for a wide range of stakeholders to express their views</li> <li>b) No formal governance role and no specific membership defined</li> </ul>
<b>Other Governance Mechanisms</b>		<p>1) There are several governance mechanisms associated with the granting process:</p> <ul style="list-style-type: none"> <li>a) Country Coordinating Mechanisms—Country level partnerships which develop and submit proposals and oversee implementation</li> <li>b) Local Fund Agents—Country level oversight, verification and reporting function hired by the Global Fund</li> <li>c) Principal and Sub-Recipients—Direct country recipient of the Global Fund grant responsible for implementation or granting to sub-recipients</li> </ul> <p>2) here are two organisational units which provide oversight and advise the Board of Directors directly:</p> <ul style="list-style-type: none"> <li>a) Technical Evaluation Reference Group—Provide independent advice and assessment reporting directly to the Board</li> <li>b) Office of the Inspector General – Independent control and risk oversight function reporting directly to the Board</li> </ul>



	<b>World Health Organization (WHO) - Constitution<sup>30</sup></b>	<b>The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) By-laws<sup>31</sup></b>
<b>Objective / Mandate</b>	“...the attainment by all peoples of the highest possible level of health.”	“...attract, manage and disburse resources through a new public-private foundation that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development Goals established by the United Nations.”
<b>Scope of Activity</b>	<p>Nine principles such as “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”</p> <p>22 functions such as “to act as the directing and coordinating authority on international health work”</p>	Not defined in by-laws
<b>Relationship to other organisations</b>	<p>May cooperate with other inter-governmental organisations and enter into formal agreement with 2/3 approval of the WHA</p> <p>May consult and cooperate with non-governmental international organisations</p>	Not defined in by-laws

**5. Comparing Resource Mobilisation: Select Figures from the Global Fund, the WHO, UNAIDS and the World Bank's Multi-Country AIDS Program (2002 to 2007)**

	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>Total 2002-07</b>
<b>Global Fund-Pledges Due<sup>32</sup></b>			3.40	1.51	2.03	2.68	9.62
<b>Global Fund-Disbursements<sup>33</sup></b>	1.37 (Round 1-Apr 02)	1.72 1.33 (Round 2-Jan 03and Round 3-Oct 03)	2.17 (Round 4-Jun 04)	1.12 (Round 5-Sep 05)	.83 (Round 6-Nov 06)	.61 (Round 7-Nov 07)	7.82
<b>WHO Total Budget (Regular and Extra budgetary funds by Biennium)</b>	2.23 <sup>34</sup> 2002-03		2.82 <sup>35</sup> 2004-05		3.67 <sup>36</sup> 2006-07		8.10
<b>WHO Expenditure (area of work) on HIV/AIDS</b>	.05 <sup>37</sup>		.13 <sup>38</sup>		.15 <sup>39</sup>		.33
<b>WHO Expenditure (area of work) on Malaria</b>	.09 <sup>40</sup>		.16 <sup>41</sup>		.17 <sup>42</sup>		.42
<b>WHO Expenditure (area of work) on Tuberculosis</b>	.08 <sup>43</sup>		.15 <sup>44</sup>		.18 <sup>45</sup>		.41
<b>UNAIDS Total Unified Budget (includes WHO contribution)</b>	.38 <sup>46</sup>		.52 <sup>47</sup>		.84 <sup>48</sup>		1.66
<b>World Bank Multi- Country AIDS Program Commitments<sup>49</sup></b>	.46		.43		Not available		
<b>World Bank Multi- Country AIDS Program Disbursements<sup>50</sup></b>	.097		.23		Not available		

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- <sup>35</sup> World Health Organization (2006) 'Financial Highlights', Biennium Financial Report 2004-2005. Geneva: World Health Organization, p. 3.
- <sup>36</sup> World Health Organization (2008) 'Financial Highlights', Biennium Financial Report 2006-2007. Geneva: World Health Organization, p. 3
- <sup>37</sup> World Health Organization (2004) World Health Organization Programme Budget 2002-2003: Performance Assessment Report. Geneva: World Health Organization, p. 6.
- <sup>38</sup> World Health Organization (2006) 'Budget and expenditure summary by area of work - all offices. Financial period 2004-2005', Biennium Financial Report 2004-2005. Geneva: World Health Organization, p. 63.
- <sup>39</sup> World Health Organization (2008) 'Budget and expenditure summary by area of work – all offices. Financial period 2006–2007', Programme budget 2006–2007: performance assessment. Geneva: World Health Organization, p. 26.
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- <sup>41</sup> World Health Organization (2006) 'Budget and expenditure summary by area of work - all offices Financial period 2004-2005', Biennium Financial Report 2004-2005. Geneva: World Health Organization, p. 65.
- <sup>42</sup> World Health Organization (2008) 'Budget and expenditure summary by area of work – all offices Financial period 2006–2007', Programme budget 2006–2007: performance assessment. Geneva: World Health Organization, p. 26.
- <sup>43</sup> World Health Organization (2004) World Health Organization Programme Budget 2002-2003: Performance Assessment Report. Geneva: World Health Organization, p. 5.
- <sup>44</sup> World Health Organization (2006) 'Budget and expenditure summary by area of work - all offices Financial period 2004-2005', Biennium Financial Report 2004-2005. Geneva: World Health Organization, p. 65.
- <sup>45</sup> World Health Organization (2008) 'Budget and expenditure summary by area of work – all offices Financial period 2006–2007', Programme budget 2006–2007: performance assessment. Geneva: World Health Organization, p. 26.
- <sup>46</sup> UNAIDS (2001) 'Unified Budget', UNAIDS Unified Budget and Workplan 2002–2003. Geneva: UNAIDS, p. 12.
- <sup>47</sup> UNAIDS (2003) 'Unified Budget', UNAIDS Unified Budget and Workplan 2004–2005. Geneva: UNAIDS, p. 13.
- <sup>48</sup> UNAIDS (2006) 'Distribution of core, supplemental, and cosponsor resources by agency', UNAIDS Revised Unified Budget and Workplan 2006–2007. Geneva: UNAIDS, p. 13.
- <sup>49</sup> Marelize Görgens-Albino, Nadeem Mohammad, David Blankhart and Oluwole Odutolu (2007) 'The Africa Multi-country AIDS Program, 2000–2006: results of the World Bank's response to a development crisis. Washington: The World Bank, p. 32.

<sup>50</sup> Marelize Görgens-Albino, Nadeem Mohammad, David Blankhart and Oluwole Odutolu (2007) 'The Africa Multi-country AIDS Program, 2000–2006 : results of the World Bank's response to a development crisis', Washington: The World Bank, p. 32.

## 6. Malawi, Rwanda and Kenya: Comparative Overview of HIV/AIDS

### Prevention Strategies for the 2009 Global Fund National Strategy

#### Applications

<b>Malawi</b>		
<i>Source: National AIDS Commission (2009) National HIV Prevention Strategy 2009-2013</i>		
<b>Outcome of 2009 NSA</b>		Failed
<b>HIV/AIDS Prevalence (overall population)</b>		12%
<b>Type of Epidemic</b>		Discordant couples=88% of new infections Mother to child=10% of new infections Other=2% of new infections (e.g. blood transfusion)
<b>HIV/AIDS Prevention Strategy</b>	<b>Human Rights</b>	<u>Approach</u> Cross cutting “Promote legal and human rights issues that reduce HIV risk and vulnerability (p. 37)”
	<b>Special Populations (Primary Focus)</b>	Sex workers – 71% prevalence Men having sex with men – 21% prevalence - limited data Prisoners – no data
	<b>Men having sex with men (MSM)</b>	Illegal in Malawi <u>Approach</u> “Data from a study which used a snowball sampling method identified 200 MSM in urban centres of Malawi, and this group had an HIV prevalence of 21%. This is particularly important because high-risk unprotected sexual contact between MSM was prevalent in the group. Many of these men have female sexual partners, thereby increasing the likelihood of HIV transmission to their female partners. Effort has to be made to reach out to MSM and their female sexual partners with appropriate prevention interventions” (p. 16). “Develop tailored interventions for populations who are vulnerable to HIV infection because of their behaviours or environments (sex workers, MSM, prisoners, etc.)” (p. 34).
<b>Rwanda</b>		
<i>Source: Government of Rwanda, Rwanda National Strategic Plan on HIV and AIDS 2009-2012</i>		
<b>Outcome of 2009 NSA</b>		Successful US\$213 mm
<b>HIV/AIDS Prevalence (overall population)</b>		3%
<b>Type of Epidemic</b>		Discordant couples=85% of new infections MSM = 15% of new infections (limited data)
<b>HIV/AIDS Prevention Strategy</b>	<b>Human Rights</b>	<u>Approach</u> ... Particular attention needs to be given to the training of health care providers to ensure that people who belong to marginalized groups receive adequate care, regardless of the prejudices service providers may have towards them. Policy analysis and advocacy activities will also be conducted where necessary. Underpinning all of these

		strategies is a commitment to ensuring greater participation of members of these groups in assessing their needs, designing programs, and advocating for necessary changes in the environment” (p. 45).
	<b>Special Populations (Primary Focus)</b>	Sex workers – no data on prevalence for any vulnerable population Prisoners Refugees Truck Drivers
	<b>Men having sex with men (MSM)</b>	Legal in Rwanda <u>Approach</u> “As of yet, Rwandan HIV policy has not addressed HIV prevention among MSM, due largely to a lack of data and due to denial about the existence of sex between men. Homosexuality is not illegal in Rwanda, but is strictly against societal norms, with a strong cultural resistance regarding its existence” (p.30). “Addressing sex between men in general, and within prisons, is a new area of work. Operational research will be carried out, and an emphasis will be placed on ensuring MSM are active in the design and implementation of these programs, to ensure that they are carried out in the most appropriate way” (p.58).
<b>Kenya</b> <i>Source: Government of Kenya, Kenya National Strategic Plan 2009/10 -2012/13: Delivering on Universal Access to Services</i>		
<b>Outcome of 2009 NSA</b>		Failed
<b>HIV/AIDS Prevalence (overall population)</b>		7.1%
<b>Type of Epidemic</b>		Discordant couples=44% of new infections Men and women engaging in casual sex=20% of new infections MSM and prison populations=15% of new infections Injecting drug users (IDUs)=3.8% of new infections Health facility related infections=2.5% of new infections
<b>HIV/AIDS Prevention Strategy</b>	<b>Human Rights</b>	<u>Approach</u> “A series of difficult legal issues arise from attempts to programme more directly for the MARPs [most-at-risk populations] (sex workers, IDUs, MSM), and to take these programmes to scale. Sex work, homosexuality and drug use are all illegal in Kenya. Programmes have been working with all these groups for many years, but under constraints. There is a need to come up with policies that will facilitate scaling up access to services by the different groups clustered under the term MARPs” (p. 9).
	<b>Special Populations (Primary Focus)</b>	Sex workers – no data on prevalence for any vulnerable population Prisoners Men having sex with men Injecting drug users
	<b>Men having sex with men (MSM)</b>	Illegal in Kenya <u>Approach</u> “It is difficult to target services effectively when so little is known about MARPs [most-at-risk populations]” (p. 6). “Cutting across all of the four strategies will be a central focus on MARPs and vulnerable groups in order to directly address existing epidemiological evidence and the sources of new HIV infections” (p.

		xiii).
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## Interviews

None of those interviewed agreed to have quotes attributed personally or directly.

Name and Title	Organisation
Dr. Rifat Atun Director, Strategy, Performance and Evaluation	The Global Fund
Anurita Bains Senior Advisor in the Office of the Executive Director	The Global Fund
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Dr. Christoph Benn Director for Partnerships, Communications and Resource, Mobilization	The Global Fund
Dr. Léopold Blanc Coordinator, Tuberculosis Strategy and Health Systems	Stop TB
Patrick Brenny UNAIDS Country Coordinator	UNAIDS, Malawi
Craig Burgess Senior Programme Officer, Health Systems Strengthening,	GAVI Alliance
Dr. Andrew Cassels, Director of Strategy, Office of the Director General	WHO
Dr. Adrienne Chan Medical Advisor	Dignitas International, Malawi
Steven Chizimbi Local Fund Agent for the Global Fund	Malawi
Paul DeLay Deputy Executive Director	UNAIDS
Helen Frary Chief of Board and UN Relations	UNAIDS
Dr. William S. Gunn Head of Emergency Relief (Retired)	WHO
Sara Hersey Epidemiologist	Center for Disease Control, Malawi
Florence Kayambo Head of Policy Support and Development	National AIDS Commission, Malawi



<b>Name and Title</b>	<b>Organisation</b>
Dr. Peter Kazembe Executive Director	Baylor College of Medicine, Children's Foundation, Malawi
Peter Killick Aid Liaison Consultant	Malawi-Canada Support Unit, CIDA
Dr. Dieter Koecher Director	GTZ, Malawi
Dr. Jason Lane Team Leader, Human Development	DfID, Malawi
Dr. Selina Lo Medical Coordinator	Access to Essential Medicines Médicins sans Frontières (MSF)
Dr. David Luke Senior Advisor and Coordinator, Trade and Human Development Unit	UNDP
Patrick Makondesa National Project Coordinator, HIV Prevention and Economic Empowerment Project	ILO, Malawi
Jacques Martin Deputy Head, UN Development Division (Retired)	SIDA and former Global Fund Board Member
Brian Mtonya Senior Private Sector Development Specialist (Author of a study on the System Wide Effects of the Global Fund in Malawi)	World Bank, Malawi
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Madolo Nyambose Assistant Director, Data and Aid Management Division	Ministry of Finance, Malawi
Mit Philips Author of 'No Time to Quit'	MSF, Brussels
Carole Presern, Acting Managing Director, External Relations	GAVI Alliance
Dr. Esther Ratsma Medical Programs Coordinator	Dignitas International
Dr. Eric Schouten Technical Assistant for Co-ordination of HIV and AIDS Programmes	Department of HIV and AIDS Ministry of Health, Malawi
Dr. Luis Andres de Francisco Serpa Team Coordinator and Special Advisor Strategy	Partnership for Maternal, Newborn and Child Health, WHO
Dr. Mary Shawa Principal Secretary for Nutrition and HIV/AIDS	Office of the President and Cabinet, Malawi
Kisimbi Thomas Director	Clinton Foundation, Malawi
Dr. Boi Betty Udom, Partnership Facilitator and	Roll Back Malaria

<b>Name and Title</b>	<b>Organisation</b>
Dr. James Banda Senior Advisor	
Vincent and Constance Social Workers	Baylor Pediatric AIDS Clinic, Lilongwe, Malawi
Dr. Tom Warne Medical Officer Care and Treatment Advisor	Center for Disease Control, Malawi

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